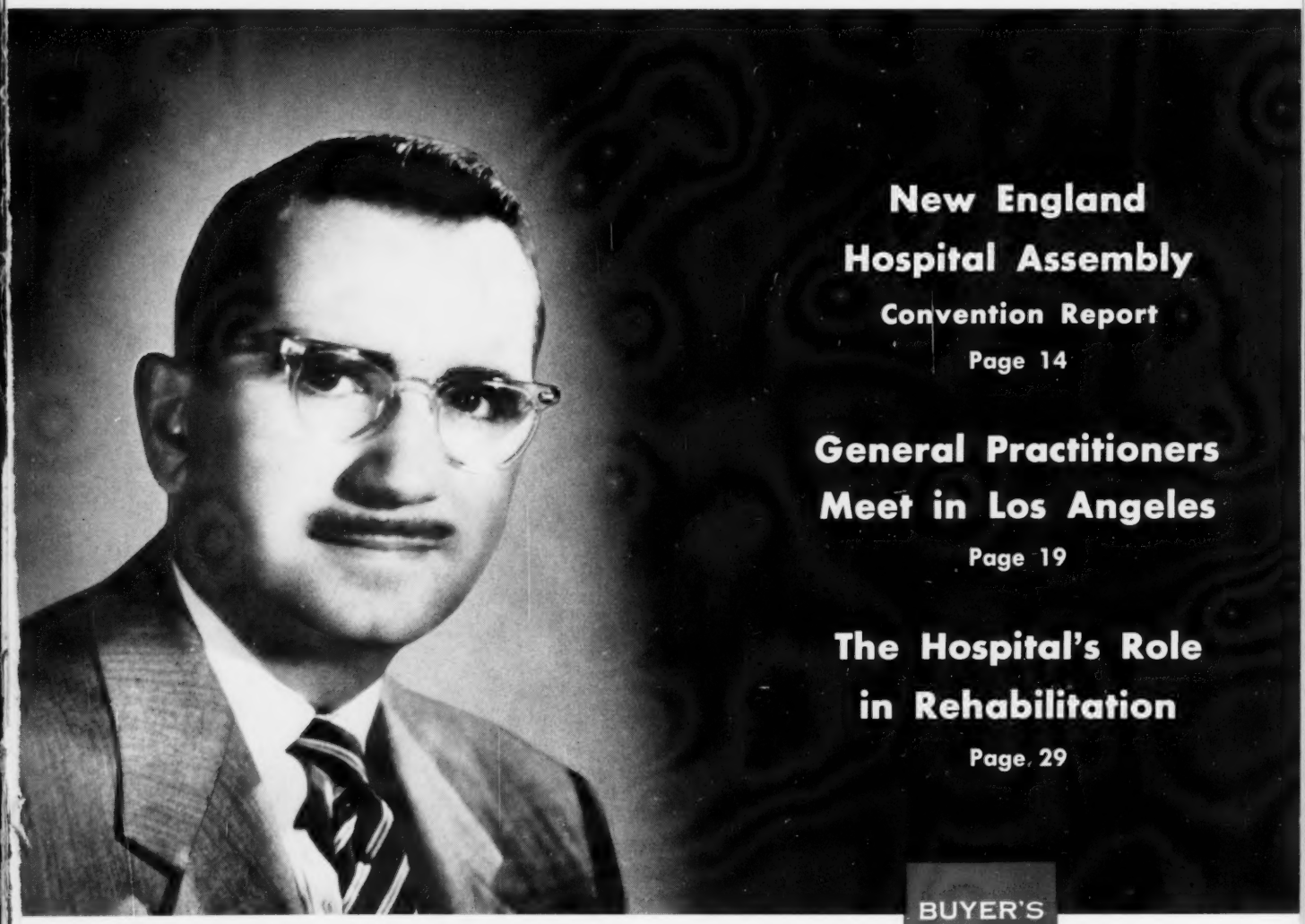
HOSPITAL
Topics
THE NEWS MAGAZINE FOR HOSPITALS



JACK A. L. HAHN

New England Hospital Assembly
Convention Report
Page 14

General Practitioners Meet in Los Angeles
Page 19

The Hospital's Role in Rehabilitation
Page 29

BUYER'S GUIDE
Page 44

MAY | 1955

"AYE!

We made it mighty HOT for these gloves ...to prove our point!"

This unretouched photograph shows eight surgeons' gloves which have really been given the "works." We wanted to separate the men from the boys, so to speak. So we put them through a series of thirty autoclavings—each one for 15 minutes under 15 pounds' pressure at 250°F. With lots of stretching between each "cooking."

The two specimens in the foreground are AMERICAN'S **Chieftain Brown Latex Gloves.** Notice how well they've stood the test. The six other brown milled gloves are obviously suffering from varying degrees of collapse—even to the point of total ruin.

There's a rather obvious moral. Nothing replaces quality. And nothing, in the long run, is so inexpensive. That's a fundamental you'll see reflected by the products AMERICAN makes or provides for the hospital field.

Suppliers of the best—for the world's best hospitals

American Hospital Supply *corporation*

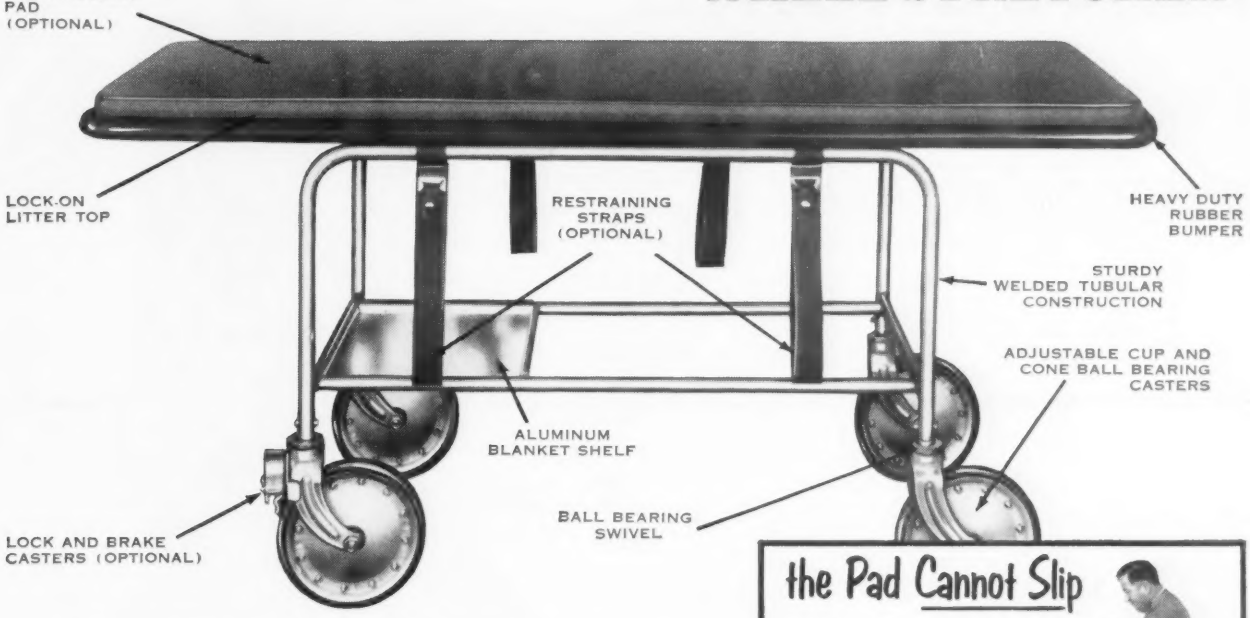
GENERAL OFFICES • EVANSTON, ILLINOIS

© AHS CORP.

THE NEW HAUSTED Economy

MODEL 1000

WHEEL STRETCHER


1-INCH FOAM RUBBER PAD (OPTIONAL)
LOCK-ON LITTER TOP
RESTRAINING STRAPS (OPTIONAL)
HEAVY DUTY RUBBER BUMPER
STURDY WELDED TUBULAR CONSTRUCTION
ADJUSTABLE CUP AND CONE BALL BEARING CASTERS
ALUMINUM BLANKET SHELF
BALL BEARING SWIVEL
LOCK AND BRAKE CASTERS (OPTIONAL)

Here is a brand new, low priced Hausted Wheel Stretcher designed for the simple transfer of patients and engineered to give hospitals years of dependable service.

The same Hausted standards of quality, workmanship and materials have been incorporated in this new Economy Stretcher making it dollar for dollar the top wheel stretcher value.

EQUIPPED WITH THESE QUALITY FEATURES:

1. Full size, 26¾" x 74" flat, 19 ga. steel litter top — slotted for straps to hold pad in position.
2. Lock-on litter top — can be removed in 1 minute.
3. Heavy duty rubber bumper surrounds litter top.
4. Sturdy welded tubular construction.
5. Aluminum Blanket Shelf.
6. 10" adjustable cup and cone ball bearing casters with ball bearing swivel joints.

HAUSTED ECONOMY MODEL NO. 1000 (Silver Lustre Finish) **$99.00**

Model 900 Stainless Steel (U-Frame, lower cross members and Blanket Shelf) . . . $160.00

the Pad Cannot Slip

3 holding straps fit through slots and fasten underneath litter top, preventing pad from sliding or slipping during patient transfer.

Optional Equipment

No. 1055	1-Inch Foam Rubber Pad with 3 attached holding straps to fit slotted litter top	$31.00
No. 1045	Lock and Brake Casters, ea.	$10.00
No. 1030	Adjustable Restraining Straps (2 pr. suggested) pr.	$6.00
No. 1056	Conductive Rubber Pad Extra	$5.00
No. 1040	Conductive Rubber Tires Extra	$5.00

the HAUSTED Manufacturing Co.

MEDINA, OHIO

ANNOUNCING

The new Seamless Crest surgeon's glove

47% thinner than any existing glove

FOR THE MOST DELICATE, EXACTING SURGERY

GOSSAMER THIN
NAKED SENSITIVITY
UNBELIEVABLY SOFT
LESS FINGER FATIGUE
"KOLOR-SIZED"—BANDED

The lightest, thinnest, most comfortable glove ever produced!

AVAILABLE AT YOUR SURGICAL SUPPLY DEALER

SURGICAL RUBBER DIVISION • **THE SEAMLESS RUBBER COMPANY**
NEW HAVEN 3, CONNECTICUT

HOSPITAL Topics

The News Magazine for the Hospital Staff

MAY, 1955, VOL. 33, NO. 5

FEATURES

Wisconsin Hospital Association Holds Annual Meeting 12
New England Hospital Assembly 14
American Academy of General Practice Meets in Los Angeles 19
HOSPITAL TOPICS Goes Calling 21
Spiritual Preparation of the Surgical Patient 24
The Hospital's Role in Rehabilitation 29
Albuquerque Plays Host to New Mexico Association 35

DEPARTMENTS

Prescription Pad 4
Clinical Notes 5
Scanning the News 7
Newsbriefs at Press Time 9
Calendar of Coming Meetings 10
O.B. Department 37
Pediatric Nursing 41
Buyer's Guide 44
Review of Hospital Law Suits 53
Personally Speaking 56
The Lab 61
Trade Topics 62
How Others Do It 64
The Book Corner 66
Central Supply Room 85

OPERATING ROOM

Fresno A.O.R.N. Holds Organizational Meeting 73
Body Temperature Studies in Anesthetized Man 74

G. M. Marshall
Publisher

J. F. Fleming, M.D.
Medical Editor

Marie Jett
Editor

Lois Smith
Managing Editor

Frances Henkin
Associate Editor

Nina Marie Stein
Editorial Assistant

Marcella Skandis
Advertising Production Manager

Gunhild Moberg
Business Manager

Published by THE HOSPITAL BUYER CO., Inc., 30 West Washington St., Chicago 2, Ill. Telephone: DEarborn 2-5148. Subscription rates: one year, $2.50; three years, $6.00; single copy, 35 cents. Canadian and foreign subscriptions: one year, $3.50; three years, $8.00; single copy, 50 cents.

A monthly publication. Entered as second class matter at the Post Office, Chicago, Illinois. Additional second-class entry at Long Prairie, Minn.

PERSONALITY OF THE MONTH

Jack A. L. Hahn, superintendent of Methodist Hospital, Indianapolis, is rapidly following in his distinguished father's footsteps. His father, Albert G. Hahn, is administrator of the Protestant Deaconess Hospital, Evansville, Ind. and executive director of the American Protestant Hospital Association.

During the time Jack studied hospital administration at Northwestern University, he served as night superintendent and administrative assistant at Wesley Memorial Hospital, Chicago. He was also president of the hospital administration student body.

After receiving his master's degree he became administrator of Memorial Hospital, Fremont, Ohio. During his five years there the hospital engaged in two expansion programs and a large public relations program. While in Ohio he served as chairman of the Institute Committee of the Ohio Hospital Association and president of the Toledo Hospital Council.

In 1953 Mr. Hahn was appointed assistant superintendent of Methodist Hospital and two years later became superintendent when Robert E. Neff retired.

Currently a 200-bed addition is being planned for the hospital through the Indianapolis Hospital Development Association. This will increase the capacity to 825 beds. An addition will also be built to the nurses' residence.

Mr. Hahn is married and has three children, Susan Louise, Louis Albert and Joan Kay. His hobbies are squash and golf.

prescription pad

Nufacton 'Organon'

Nufacton is the basic therapeutic formula designed expressly to treat stressful situations which result in loss of the water-soluble vitamins B and C. Each Nufacton tablet contains Bifacton (vitamin B12 with Intrinsic Factor Concentrate), ½ U.S.P. oral unit; folic acid, 5 mg; thiamin HCl, 5 mg; niacinamid, 75 mg; riboflavin, 5 mg; ascorbic acid, 100 mg; pyridoxine HCl, 5 mg; and d-panthenol, 4.31 mg (equivalent to 5 mg of calcium pantothenate).

Nufacton is recommended for the treatment and prevention of vitamin B and C deficiencies recommended by one of America's foremost authorities on nutrition—Tom D. Spies, M.D. It contains Bifacton, which, by combining and binding vitamin B12 with sufficient intrinsic factor, assures bodily absorption of vitamin B12. In addition, Nufacton supplies for the first time enough of the essential folic acid to treat nutritional deficiencies resulting from stressful periods, and liberal amounts of ascorbic acid and the B vitamins to replenish depleted body stores of these vital nutrients.

As a dietary vitamin supplement, the recommended dosage of Nufacton is one or two tablets a day. It comes in boxes of 24 stripped tablets.

Anticholinergic-Sedative

Monodral with Mebaral contains 5 mg. Monodral bromide and 32 mg. (½ grain) Mebaral per tablet.

Monodral bromide is a potent, well tolerated anticholinergic agent for peptic ulcer, hyperacidity, gastritis, pylorospasm, spastic and irritable colon. It produces marked inhibition of gastric secretion frequently to the point of anacidity. It causes powerful reduction of hypermotility and spasm of the stomach and small intestine, and produces rapid and prolonged relief from pain and favors ulcer healing. Constipation and other troublesome side effects are uncommon.

The use of a sedative has become established clinical practice as a rational adjunct to the general and specific management of peptic ulcer and hyperactivity of the gastro-intestinal tract. Mebaral, a well established reliable sedative and antispasmodic, produces tranquility and diminishes gastro-intestinal irritability. It causes little or no drowsiness and is relatively free from side effects.

While Monodral reduces activity of the parasympathetic nervous system, Mebaral diminishes central nervous system excitor stimuli from the cerebrum to the bowel. The combined action promotes rest, tranquillity and relaxation of the apprehensive, excited or anxious patient. This effectively breaks the vicious cycle of excitation, hypermotility and hypersecretion of the person with a hyperactive bowel.

The dosage of Monodral with Mebaral should be individualized to meet each patient's requirement. Average peptic ulcer patient, one tablet three or four times daily. Some patients may require larger doses during the first few days of medication to bring symptoms under control. Daily dose of eight tablets should not be exceeded nor given for long periods. Other gastro-intestinal disorders (hyperacidity, astritis, pylorospasm, "spastic" and "irritable" colon), one tablet three or four times daily. When symptoms are controlled, smaller doses usually suffice to maintain relief.

Monodral with Mebaral is supplied by Winthrop-Stearns, Inc., in bottles of 100 tablets.

- *They offer you permanent records for various department uses and can be retained for years*
- *They facilitate both the making of entries and the location of needed data*
- *They meet the requirements of the Joint Commission on Accreditation and other agencies*
- *They are available in various sizes to fit your needs and are always kept in stock, assuring prompt delivery*
- *They can be furnished either in bound-book or loose-leaf style*
- *They require very little space for storing and are economical in price*

FOR FREE SAMPLES WRITE DEPT. HT-555

PHYSICIANS' RECORD COMPANY

Publishers of HOSPITAL *and* MEDICAL RECORDS *Since 1907*

161 West Harrison Street · CHICAGO 5, ILLINOIS

clinical notes

New Antihistaminic For Allergy Relief

Beale, Rawling, and Figley, in the *Journal of Allergy*, report on a study conducted on 126 patients from private practice. All were suffering from severe allergic symptoms not relieved by other measures, and all were given Clistin. Of these patients, 113 had allergic rhinitis; 11 urticaria; 1 asthma; 26 allergic rhinitis and asthma; 1 allergic conjunctivitis.

Of those patients receiving the 4 mg. dose of the drug, 87 percent noted some degree of relief, and in 47 percent this relief was marked to complete. Of those receiving the 6 mg. dose, 80 per cent obtained some benefit, with marked to complete relief in 37 per cent. All patients taking larger doses received some relief.

Onset of action of the drug usually was 30 to 60 minutes; duration of action approximately 4 hours. Side effects were negligible. The most common was drowsiness, but in only 4 percent was this sedation considered to be of moderate or severe degree. Drowsiness, when it did occur, seemed to disappear after a few days despite continued medication.

Although it has generally been found that the most potent antihistaminic drugs are moderately or highly sedative in action, results of this study indicate that this compound, known chemically as carbinoxamine maleate, is a potent antihistaminic agent with only weak sedative properties, and should be a useful adjunct in treating allergic conditions.

Treatment of Upper Gastrointestinal Disorders

Pomeranze, Beinfield, Goldbloom, Lucariello, and Chessin of New York report on a study of 63 patients with disorders included pylorospasm and conditions associated with gastric motor dysfunction and biliary dyskinesia.

The authors found Dactil to be particularly useful for ambulatory working patients in whom immediate activity without side-effects is essential to prevent invalidism and loss of productivity.

The activity of the drug became apparent within 10 minutes of oral ingestion and in most cases was prolonged for three to four hours. It was this rapidity of action that focused attention upon its therapeutic value.

The study also indicates an excellent parasympathicolytic activity confined to the upper gastrointestinal areas.

As an example of the drug's efficacy, the authors report on four patients with pylorospasm and delayed emptying of the stomach unassociated with evidence of organic disease. The patients were fluroscoped within 10 minutes of the oral administration of 50 mg. of Dactil. The stomach was seen to empty rapidly, indicating relief of spasm.

In 18 cases of gastric neurosis, eight patients had excellent response and eight good.

Weck Specialties

FOR CENTRAL SUPPLY SERVICE

Tongue Depressors

Save valuable time and labor in the distribution of small quantities of wooden tongue depressors by using the new Weck packaging–individually wrapped in paper ready for sterilizing. This eliminates re-packaging from your bulk packages.

51-820 Tongue Depressors (6" x ¾")
packed 500 in box — minimum order

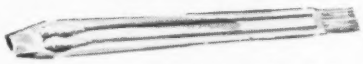
2 boxes ..... $ 4.00
10 boxes (5000 depressors) in a case 19.00

Blood-pressure Washable Cuffs

Something new! – made of finely woven balloon cloth. They're snowy white – and will *stay that way* for they can be washed and washed and washed. Can be sterilized, too!

42-310 Washable Blood-pressure Cuff
each $2.00

Cotton-tipped Applicators



The handy new Weck packaging - two applicators in a glassine envelope ready for sterilizing – means prompt and efficient service at all times (especially in distributing small quantities).

51-784 Cotton-tipped Applicators (6" long)
Packed 500 envelopes of 2 Applicators (1000 Applicators) in a box

Per box ..... $ 7.00
2 boxes (2000 Applicators)..... 13.50

WECK Cleaner

– the only surgical instrument cleaner made by a surgical instrument manufacturer. Removes clotted blood – cleans effectively even in the hardest water – foam-proof – dissolves rapidly–wets, penetrates, dislodges and emulsifies all soils rapidly.

56-580 Weck Cleaner—prices per 5 lb. can with measuring spoon:

1 can—$5.30 3 cans—$5.00 each
6 cans—$4.80 each 12 cans—$4.60 each

Your orders will receive prompt attention. Let us add your name to our list to receive regular mailings of Weck Specialties for Central Supply Service.

65 years of knowing how WECK **EDWARD WECK & CO., INC.**
135 JOHNSON ST., BROOKLYN 1, N. Y.

Manufacturers of Surgical Instruments • Hospital Supplies • Instrument Repairing

prevents postpartum hemorrhage
speeds uterine involution

Lilly
QUALITY / RESEARCH / INTEGRITY

'Ergotrate Maleate'

(ERGONOVINE MALEATE, U.S.P., LILLY)

... produces rapid and sustained contraction of the postpartum uterus

The administration of 'Ergotrate Maleate' almost completely eliminates the incidence of postpartum hemorrhage due to uterine atony. Administered during the puerperium, 'Ergotrate Maleate' increases the rate, extent, and regularity of uterine involution; decreases the amount and sanguineous character of the lochia; and decreases puerperal morbidity due to uterine infection.

Dosage: Generally, 0.2 to 0.4 mg. I.V. or I.M. immediately following delivery of placenta. Thereafter, 0.2 to 0.4 mg. three or four times daily for two weeks.

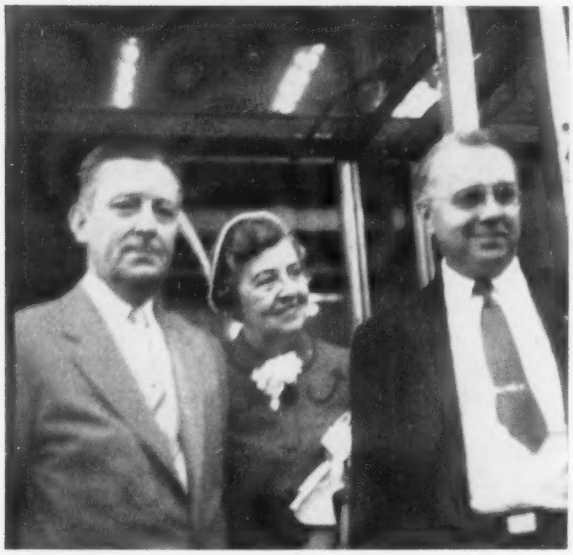
Supplied:
Ampoules of 0.2 mg. in 1 cc.
Tablets of 0.2 mg.

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

HOSPITAL Topics
The News Magazine for the Hospital Staff

VOL. 33, NO. 5
MAY, 1955

Scanning the News



Above: Pictured in Chicago at the closed circuit TV report to physicians on the Salk poliomyelitis vaccine are (l. to r.): George M. Moore, District Manager, Eli Lilly and Company, Frances L. Karlsteen, Executive Director, Cook County Chapter, National Foundation of Infantile Paralysis, and Martin H. Seifert, M.D., Medical Advisory Board, Cook County Chapter, National Foundation of Infantile Paralysis. The television program was prepared by Eli Lilly and Company with the cooperation of the Foundation, and was shown in major cities across the nation.

Music Used to Diagnose Mental Ills

Music may soon be used as a tool for determining whether or not a person is suffering from a mental illness.

A new test which depends on what type of music the patient prefers, has been devised by Raymond B. Cattell and Jean C. Anderson of the laboratory of personality assessment and group behavior at the University of Illinois.

When musical excerpts were played to patients at Manteno State Hospital, it was shown that the schizophrenics and paranoids preferred music that was rather slow, simple and sad. The manic depressives showed a preference for fast and exhilarating music.

Pleasant Effects of Narcotics Disproved

Most narcotics commonly believed to give pleasant effects merely have a depressing effect on normal persons, according to a report in a recent *Journal of the American Medical Association* by Louis Lasagna, M.D., John M. von Felsinger, M.D., and Henry K. Beecher, M.D., all of the Harvard Medical School and the Massachusetts General Hospital.

Of the 80 volunteers tested, 20 were healthy young male students, 30 were chronically ill, old and hospitalized, and 30 were postaddicts from the U. S. Public Health Service Hospital at Lexington, Ky.

None of the volunteers knew whether they were receiving drug shots or a salt solution, the doctors said. Among the healthy and chronically ill, even a narcotic which at first seemed pleasant soon became depressing and unpleasant. Those who were ill said that any pleasure was due to relief from pain.

The reaction of addicts or those undergoing treatment for addiction differed somewhat. These persons claimed that drugs improved their ability to think. The physicians believe, however, that many of the reactions of postaddicts depend on previous experience.

Gum Chewing Shown to be Useful in Cutting Tooth Decay

Chewing gum after eating foods containing sugar may be beneficial in cutting tooth decay. Recent studies have shown that it is not the amount of sugar eaten but the amount that sticks to the teeth that causes the decay.

Results of tests showing that gum chewing steps up the flow of saliva and thereby clearing the mouth of decay-producing sugars were presented at a recent meeting of the International Association of Dental Research in Chicago by Drs. A. Albert Yurkstas and William A. Emerson of Tufts Dental School.

In the experiments, two groups of volunteers rinsed their mouths with a sugar solution, one group chewed a stick of gum, and a control group got nothing. The researchers found the acid formation in the film over the teeth was slowed down by 36 percent in the gum chewers.

Vitamins in Pre-Natal Care Affect Intelligence of Child

Vitamins given to poorly fed mothers during pregnancy and while nursing result in babies with a higher I.Q., according to a report from Teachers College, Columbia University.

The tests were conducted during a seven-year period in Norfolk, Va., and the Cumberland Mountains of eastern Kentucky. Three-quarters of the women were given vitamin pills and the rest received placebos. Children of the vitamin fed mothers scored a few points higher in intelligence tests than the children of mothers not getting the vitamin supplement.

Hospital Patients Test Beer

The theory that beer is harmful to heart and kidney patients is being tested at County General Hospital, Milwaukee, under a grant made by the Brewery Industries Research Foundation to the Marquette University Medical School.

These patients, who are normally on a low sodium diet, are being given beer in unlabeled containers. Researchers check the sodium content of the various types of beer.

It is hoped that a low sodium brew may be utilized to pep up the usual tasteless, salt free diet without injury to the patient.

Easier and Faster to Use

PRESCO
AUTOMATIC "SNAP-ON"
IDENTIFICATION
BRACELETS!

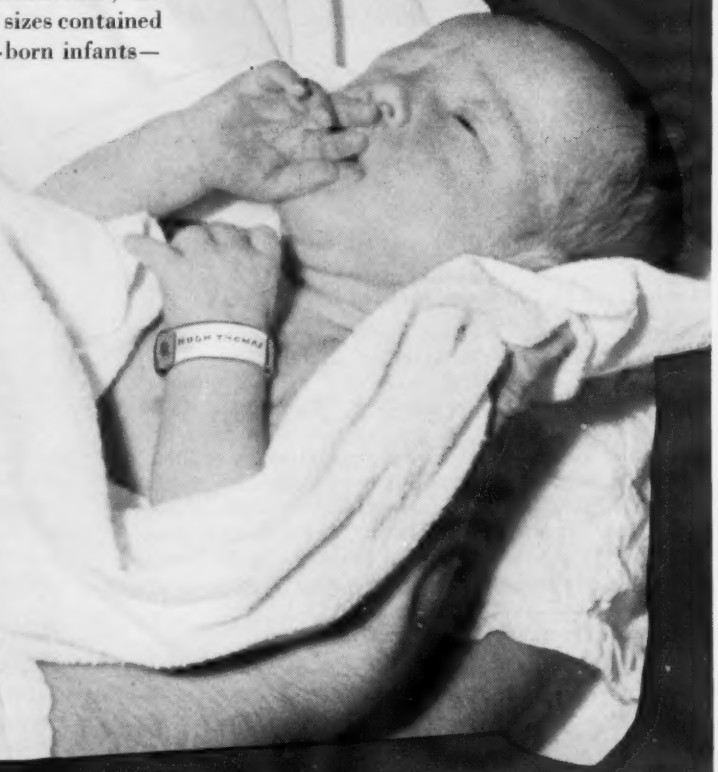
IT COSTS NOTHING TO USE THIS AMAZINGLY SIMPLE IDENTIFICATION SYSTEM . . .

• This bracelet is designed for hospitals that want to spend an absolute minimum of time and effort—with no sacrifice in positive infant identification.

The pliable, non-toxic, plastic straps (pink and blue) are pre-cut for size, and pre-assembled. (The three sizes contained in each kit will fit more than 95% of all new-born infants—sufficient adjustable straps are included to fit all others.) Simply type or print name on the card, slip it in the transparent holder, place the bracelet around infant's wrist and snap-lock it into place. Positive fasteners are an integral part of the strap. It's all done in a jiffy!

Parents invariably want to buy these bracelets as treasured keepsakes...so they more than pay their own way.

for ***free samples****,*
write the PRESCO COMPANY, INC.,
Hendersonville, N. C.



PRESCO BABY KIT

contains 144 complete bracelets in assortment of three sizes, pink and blue, $59.75. Snap-on bracelets also available in re-fill packs. Small size in packs of 12. Medium and large in packs of 36. Pink or blue.

FOR ADULTS

PRESCO has special adult size bracelets especially recommended for use in surgical cases and in multiple-bed rooms. They're a never-failing "double-check" in the cause of complete accuracy.

Order from any one of these Distributors

AMERICAN HOSPITAL SUPPLY CORPORATION
2020 Ridge Ave., Evanston, Illinois

W. D. ROE COMPANY
1831 Olive St., St. Louis 3, Missouri

WM. ROSS, INC.
4283 N. Port Washington Rd.
Milwaukee 12, Wisconsin

MEINECKE & COMPANY, INC.
225 Varick St., New York 14, New York

KLING
conform bandage
• clings to itself • elastic • conforms easily
Johnson & Johnson

head rolls

burn dressings

the new

KLING

a natural cotton product

clings to itself–prevents slipping

stretches–to allow controlled pressure

conforms easily–to any body contour

- *pre-bagged, ready for autoclaving*
- *rolled in 5 yard lengths*
- *available in* **2", 3", 4", 6"** *widths*

five yards (stretched)

breast dressings

Johnson & Johnson

News Briefs at Press Time

AHA Favors Hill Bill For Financing Practical Nurses' Training

AHA believes Senator Hill's bill to finance training of practical nurses, rather than administration bill, will come closer to solving the problem.

Secretary Hobby's objections to Hill bill: (1) It would be a permanent rather than a five-year program; (2) it would exempt states from contributing matching funds for first two years; (3) it would also provide for training of laboratory assistants, dietetic aides, other auxiliary personnel; (4) it would help defray hospitals' overhead costs, and would impose unduly restrictive federal controls.

AMA opposes both bills—says no emergency has been demonstrated.

Administration Bills Seem Doomed

Prospects are poor for most of administration's health bills—reinsurance, mortgage loan insurance, subsidies for graduate nurse training, changes in system of awarding public health grants, contributory health insurance for federal employees, increased medical care benefits for servicemen's dependents.

Even doctor-draft extension and proposed military medical and dental scholarships face rough going.

Rehabilitation Grants Offered Schools and Hospitals

Thirty-three teaching hospitals, all medical schools, and 50 schools of nursing were invited by Office of Vocational Rehabilitation to submit applications for OVR teaching grants by May 1 deadline.

Most grants will be for one year, beginning July 1. Funds allocated to medical schools and hospitals with residencies in physical medicine and rehabilitation will be used to establish or strengthen rehabilitation instruction and help finance short-term courses for physicians.

Training grants are also offered to physicians who have completed at least one year's internship and are sponsored by institutions approved by OVR for rehabilitation training. Applications for these grants must be received at least 60 days prior to beginning of training period.

Washington Law Allows Physicians To "Clean Own House"

Physicians in Washington state, under a new law, now have the legal right, through a newly created board, to discipline unethical members of the profession without revoking their licenses.

Washington is first state to adopt such a law, which provides for suspension of licenses for other disciplinary actions for minor offenses. Medical profession provides funds for administering act.

Problem of Aging Vets

Nearly 10 percent of all veterans treated on any day in VA hospitals are over 65 years old, yet only five percent of nation's veterans are in that age group. To avoid future overcrowding of hospitals, as today's young vets grow older and require more treatment, VA is expanding rehabilitation program—also studying use of convalescent nursing or private homes in vets' own communities.

Briefest Briefs

University of Chicago has opened a $60,000 clinic for psychiatric treatment of emotionally disturbed children...National committee has been formed to work for passage of nursing survey bill sponsored by Rep. Frances P. Bolton (Rep., O.)...Malpractice complaints against government physicians continue to increase—often based on alleged failure to discover disease condition, rather than wrong treatment of it.

Gordon W. Marshall

Calendar of Meetings

MAY

2- 5 Tri-State Hospital Assembly
Palmer House, Chicago

2- 5 National League for Nursing
Kiel Auditorium, St. Louis

9-11 Canadian Hospital Association, Biennial Meeting, Chateau Laurier Hotel, Ottawa, Ont.

9-12 American Psychiatric Association
Atlantic City

11-13 Upper Midwest Hospital Conference
Hotel Nicollet, Minneapolis

16-19 Catholic Hospital Association
Kiel Auditorium, St. Louis

19-21 Tennessee Hospital Association, Chattanooga

23-27 American Osteopathic Hospital Association Medical Record Librarian Training School, American Osteopathic Association, Chicago

25 Massachusetts Hospital Association
Hotel Statler, Boston

25-27 Middle Atlantic Hospital Assembly
Convention Hall, Atlantic City

JUNE

2-4 National Executive Housekeepers Association Eastern District Conference
Warwick Hotel, Philadelphia

6-10 American Medical Association
Auditorium, Atlantic City

12-17 American Society of Medical Technologists, Jung Hotel, New Orleans, La.

20-24 American Physical Therapy Association
Hotel Jefferson, St. Louis

29-July 2 American Surgical Trade Association
Ambassador Hotel, Los Angeles

JULY

18-22 American Osteopathic Association, Hotel Statler, Los Angeles

SEPTEMBER

17-19 American College of Hospital Administrators, Traymore Hotel, Atlantic City

19-22 American Hospital Association
Traymore Hotel, Atlantic City

19-22 American Association of Nurse Anesthetists, Ritz-Carlton Hotel, Atlantic City

OCTOBER

3- 7 American Association of Medical Record Librarians
LaSalle Hotel, Chicago

6- 7 Mississippi Hospital Association
Hotel Buena Vista, Biloxi

19-20 Washington Hospital Association
Davenport Hotel, Spokane

29-30 American College of Osteopathic Hospital Administrators Annaul Meeting, Statler Hotel, Washington, D.C.

30-Nov. 2 American Osteopathic Hospital Association, Hotel Statler, Washington, D. C.

NOVEMBER

7- 9 Association of Military Surgeons of the U. S., Hotel Statler, Washington, D. C.

14-18 American Public Health Association
Municipal Auditorium, Kansas City

19-21 American Surgical Trade Association
Semi-Annual Meeting and Technical Exhibit, Conrad Hilton Hotel, Chicago

29-Dec. 2 AMA Clinical Session
Boston, Mass.

MISS PHOEBE

NO. 6 IN A SERIES
IDEA BY PAT HERMAN, SPOKANE

"O. K., so you feel safer in an E & J chair—but you still gotta buy a ticket!"

E & J chairs are built to "take it." And they retain their gleaming finish and smooth operating performance year after year with little or no maintenance cost. For wheel chair economy over the years, it pays to buy E & J's today.

Your favorite dealer will agree it's wise to Specify **EVEREST & JENNINGS** chairs in *your* hospital.

EVEREST & JENNINGS, INC., 1803 PONTIUS AVE., LOS ANGELES 25, CALIF.

A forward trend in complete

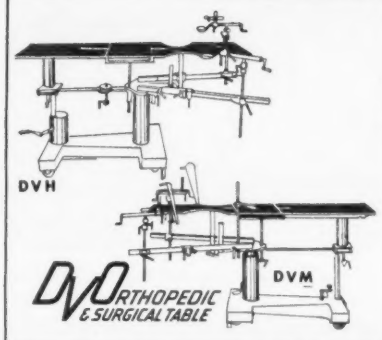
HOSPITAL ORTHOPEDIC and FRACTURE EQUIPMENT

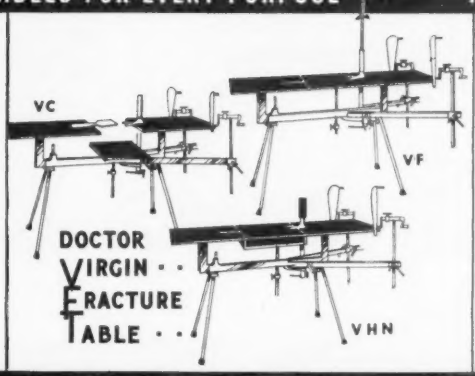
for every Hospital

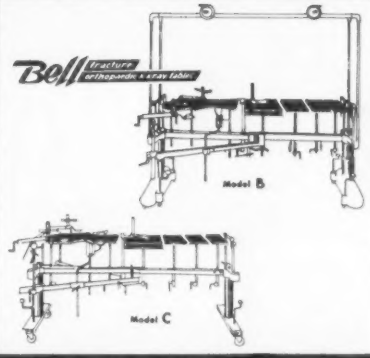
The Gilbert Hyde Chick Company, with one of the most complete, modern plants in the industry, manufactures and distributes direct to the hospitals of the world, all of its distinctive line. With representatives in principal cities, the Chick organization is in constant contact with the profession, studying its needs, and fulfilling its requirements with equipment specifically designed, perfected and manufactured to set trends in the most advance practices of the profession.

For complete information and a demonstration on any Chick Equipment write us today or call the representative nearest you.

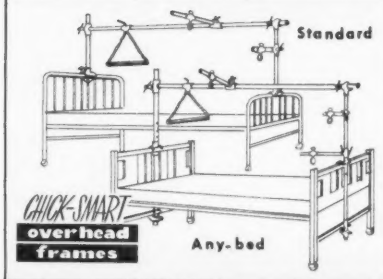
ORTHOPEDIC & FRACTURE TABLES FOR EVERY PURPOSE — FOR EVERY HOSPITAL

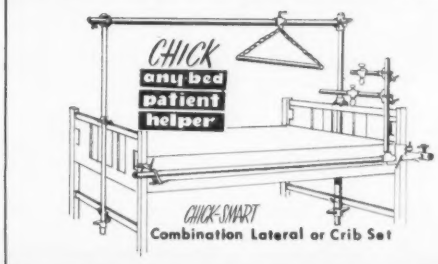


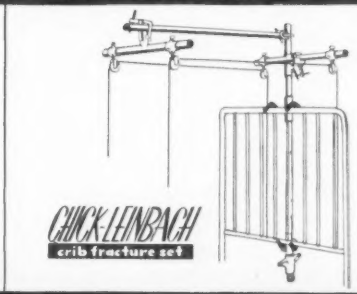




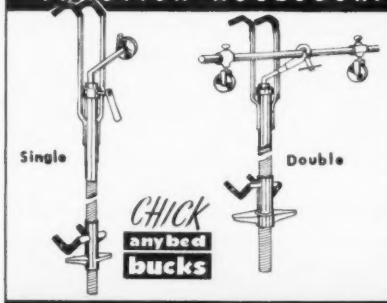
A FRACTURE FRAME FOR ANY BED OR CRIB . . . FOR ANY PURPOSE

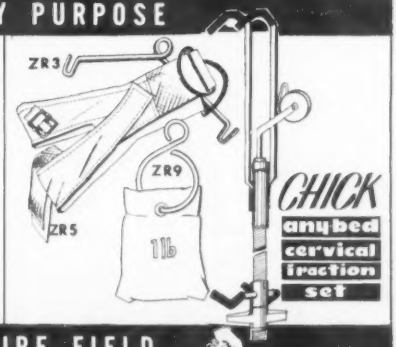




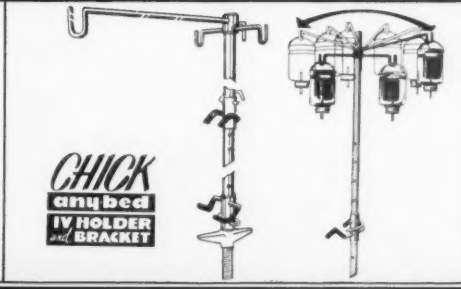


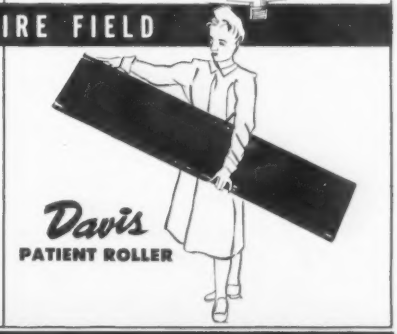
TRACTION ACCESSORIES FOR ANY BED . . . FOR ANY PURPOSE





DISTINCTIVE & USEFUL SPECIALTIES FOR THE ENTIRE FIELD





GILBERT HYDE CHICK COMPANY

MANUFACTURERS & DISTRIBUTORS OF HOSPITAL ORTHOPAEDIC & FRACTURE EQUIPMENT

MAIN OFFICE AND FACTORY: 821 75TH AVENUE, OAKLAND 21, CALIFORNIA

Above: Recently elected officers of the Wisconsin Hospital association include (l. to r.): S. K. Hummel, administrator, Columbia Hospital, Milwaukee, incoming president; Mrs. Mary Evans, Municipal Hospital, Beloit, outgoing president, and Riley McDavid, administrator, Kenosha (Wis.) Hospital, president-elect. For names of the other new officers, see article below.

Wisconsin Hospital Association Holds Annual Meeting

● Accreditation problems, patient care and the development of regional councils were discussed at the annual convention of the Wisconsin Hospital Association held in Milwaukee, March 17. Registration was 437, the largest in the association's history.

Highlight of the morning session was a panel discussion on different aspects of hospital patient care. N. J. Panella, Guidance Director, Waukesha (Wis.) High Schools, spoke from the patients viewpoint, stressing the need for good orientation programs on hospital routine for patients. James Conley, M.D., Columbia Hospital, Milwaukee, emphasized the importance of good hospital public relations, while Margaret Emanuel, Director of Nursing, Luther Hospital, Eau Claire, Wis., speaking for nurses, pointed out the need for a realistic division of duties among professional and non-professional nursing personnel. Dagmar Tuomin, Dietitian, Milwaukee County Institutions, spoke on diet problems. *(An abstract of Miss Tuomin's speech appears at the end of this article).* Bert Stajich, assistant administrator, Columbia Hospital, Milwaukee, concluded the panel. One of the chief functions of the admitting department in a hospital, he said, is to determine the type of accommodation that will meet the need yet not strain the pocketbook of the individual.

The annual award of merit of the Wisconsin Hospital Association was presented to Harold M. Coon, M.D., Superintendent of the University of Wisconsin Hospitals, Madison, Wis., for his contribution in the national as well as the local field. The presentation was made at the annual luncheon, by Joseph G. Norby, former administrator, Columbia Hospital, Milwaukee.

New officers elected by the association are: Riley McDavid, administrator, Kenosha (Wis.) Hospital, president-elect; Stewart Hummel, administrator, Columbia Hospital, Milwaukee, president; John W. Rankin, director, Milwaukee county institutions and departments, first vice-president; Sister Kathleen, St. Mary's Hospital, Wausau, second vice-president; Robert Griffiths, administrator, Burlington (Wis.) Memorial Hospital, treasurer. Harold M. Coon, M.D., Madison, was re-elected trustee. N. E. Hanshus, manager, Luther Hospital, Eau Claire, Wis., was re-elected executive secretary.

Following are abstracts of two of the speeches presented at the meeting.

Responsibility of Medical Staffs in the Accreditation Program

A. J. McCarey, M.D., President, State Medical Society of Wisconsin, Green Bay—One of the most important things in a hospital is harmony between the medical staff, the board of trustees and the administrator. All three have the same goal—to provide every patient with a high quality of medical care.

It is generally recognized that hospital governing boards and administrators should not attempt to tell physicians how to practice medicine; but the medical staff is responsible to the administrator and governing board for providing good medical care.

The staff must be a self-governing body. Its organization differs somewhat, depending on whether it is a large well departmentalized city hospital staff with interns and residents, or whether it is a small hospital located in a less densely populated area. In the former, the patients' medical records are studied at least monthly by clinicopathological conferences of each department; meetings of the whole staff are held only quarterly. In the latter, staff conferences are held monthly by the whole staff and departmentalization is not required. Since the purpose of these meetings is to improve the quality of medical care in the hospital the presentation and discussion of scientific papers has no place at these conferences. For the same reason the staff meetings of two hospitals may not be combined, nor can a staff conference be held in conjunction with any medical society meeting.

There are five required committees: An executive, credentials, joint conference, medical records, and tissue com-

mittee. For liaison with the board of trustees a good plan is to have the executive committee of the medical staff meet at certain intervals with a similar committee from the board.

The Joint Commission program for accrediting hospitals has resulted in better hospitals and improved medical care. It has had a definite impact upon the medical profession. The conscientious physician is interested in the opportunity to practice good medicine. The accredited hospital provides him with the place in which he may do this.

Patient Care by the Dietitian

Dagmar Tuomin, dietetic supervisor, Milwaukee County Institutions and Departments—The dietitian occupies a most unique position, for every patient that arrives in a hospital is an authority on what he likes to eat and how it should taste. The dietitian can plan the menus, requisition food and supervise food preparation with that in mind. Specifically, for each patient she must be sure that the tray served is in accordance with the diet ordered by his physician.

Team work on the part of the administrator, nurse, doctor and the dietitian is necessary The administrator must recognize the importance of food service, and provide facilities which will result in food of proper temperature. Priority should be given food service at meal hours, so that as many hands as possible are available for passing trays and feeding patients that need to be fed. Food trucks should be given priority on elevators, and they should not have to wait while deliveries of ice, pharmacy, central supply and laundry are completed.

The therapeutic diet is dependent entirely upon the cooperation of the medical staff. Many problems occur, because patients are placed on therapeutic diets without previous warning from the physician. If the patient were told what to anticipate he would be more willing to accept any diet, treatment, or test given at the hospital. An informed patient is a happier patient, but the one to do the informing is the doctor.

The patient should be visited at least once during his stay by the dietitian and asked if he is enjoying his meals. This visit does much to make the patient feel more kindly toward the hospital.

Above: Harold M. Coon, M.D. (l.), superintendent, University of Wisconsin hospitals, is shown receiving the Wisconsin Hospital Association's annual Award of Merit from Joseph G. Nordby, former administrator, Columbia Hospital, Milwaukee.

Above: The Wisconsin State Hospital Auxiliary held their convention concurrently with the Wisconsin Hospital Association. Pictured are (l. to r.): Rubie Carlson, Administrator, Platteville Municipal Hospital, and Mrs. J. W. Conklin, Coordinator, Committee on Hospital Auxiliaries, Wisconsin Hospital Association.

Below: After an early morning round table discussion Sister Mary Angelica (l.) laboratory technician, and Sister Mary Vincent, administrator, both of St. Catherine's Hospital, Kenosha, stop in the hallway to talk a moment before going on to other meetings.

Relaxing for a moment from their duties in the receiving line are (l. to r.): Dana Thompson, director, Central Maine General Hospital, Lewiston, Me.; Abbie Dunks, director, Boston (Mass.) Dispensary; and Richard Viguers, administrator, New England Center Hospital, Boston, new president of the New England Hospital Assembly.

New England Hospital Assembly

● *The 32nd annual meeting of the New England Hospital Assembly was held in Boston, March 28-30. More than 6,000 persons attended. One of the outstanding features was a series of 27 one and a half-hour Instructional Conferences dealing with the specific problems most often confronting administrators and other hospital personnel. The conferences were designed to be short courses in special areas of hospital administration. Although it was originally intended to limit each class to 25 persons, the attendance was so great that most classes reached twice that size.*

Abstracts of some of the papers presented at the general meeting follow.

Physical Medicine and Rehabilitation as Applied to Geriatrics

A. B. C. Knudson, M.D., Chief, Physical Medicine and Rehabilitation Service, Veterans Administration, Washington, D. C.—Physical medicine and rehabilitation is making a definite contribution to the restoration of the geriatric patient. The application of physical medicine and rehabilitation principles and procedures for the prevention, diagnosis, treatment and rehabilitation of geriatric illness and disability has produced dynamic results. Adequate rehabilitation counseling, activities of daily living, reconditioning procedures within physical tolerance and medical guidance for selective placement in employment are all important facets of this work.

Aging may be considered that larger component which frequently includes concommitant chronic illness and severe disability. They may exist in the same patient at the same time and in any number, combination or degree of severity. Aging would appear to be that catalyst which effectively brings about a reaction of hopelessness. The net result is one of absent, or at most, passive action in the direction of rehabilitation and readjusting the patient.

Among the basic things needed to solve this problem is a dynamic rehabilitation regimen. The conditions which afflict aging patients offer especially favorable clinical

Below: Speaking on a "Coordinated Approach to Geriatrics" panel were (l. to r.): John J. Gallagher, assistant manager, VA hospital, Boston; Robert T. Monroe, M.D., senior associate in Medicine, Peter Bent Brigham Hospital, Boston; Joseph Tansey, M.D., associate medical director, John Hancock Life Insurance Company, Boston; James F. Conner, M.D., chief, professional services, VA Center, Kecoughtan, Va., and A. B. C. Knudson, M.D., chief, physical medicine and rehabilitation service, VA. Washington, D. C.

Above: A Trustee Institute on developments in the health field was part of Tuesday's program. Speakers included (l. to r.): Francis D. Moore, M.D., surgeon-in-chief, Peter Bent Brigham Hospital, Boston; Basil C. MacLean, M.D., commissioner, Department of Hospitals, City of New York, N. Y.; William L. Wilson, administrator, Mary Hitchcock Memorial Hospital, Hanover, N. H., and past president, New England Hospital Assembly; and Edwin L. Crosby, M.D., director, American Hospital Association, Chicago, Ill.

opportunities for the application of physical medicine and rehabilitation methods. A rehabilitation program, in addition to helping these patients achieve a fuller life of comfort and usefulness, pays off economically.

The Mounting Cost of Providing Proper Laboratory Service

Harold L. Hutchins, Jr., Director, Pittsfield (Mass.) General Hospital—In the last 25 years there has been a marked increase in the cost of providing laboratory service, due to advances in medical skills, new tests, new equipment, and larger staffs.

The medical staff wants the service and orders it. The patient wants the service too, but can't understand the problem of increased cost. This attitude could serve as an opening wedge for compulsory health insurance.

How can we get the public to understand and be willing to pay for these present day methods of service?

Some progress along these lines has been made by making good use of the press, TV and radio in getting the hospital story across. I feel we should make better use of the technics which big business has been using successfully.

For each dollar we spend to provide the services asked for by the clinician and the pathologist, we must have a dollar rung up in the cash register. Where are we going to get these all-important dollars? About 75 percent of the patients have their bills paid for on a contractual basis which means quite often the hospital has to be satisfied with something less than current cost. Income from endowments and the efforts of even large and active auxiliaries is not enough.

The problem can be met only by going to the public and raising the money by subscription. Only if the public is willing to pay for and afford the service it has come to demand, can hospitals provide such service. If hospitals fail in this sales program—and that is really what it is—it can lead toward compulsory health insurance.

Broadening Patterns of Ambulatory Care

George A. Silver, M.D., Chief, Division of Social Medicine, Montefiore Hospital, New York, N. Y.—Home care at Montefiore Hospital was planned with the purpose of bringing hospital-type medical care into the home.

The basis of the home care operation is the basis of all good hospital operations—the medical team. The doctor, nurse and social worker can talk together and act as a unit in the patient's interest. A unit record is kept in the home care center, and all of the team puts notes on the chart. Rounds are made in the homes of the patients on a regular basis by the chief of the home care service. Consultants are called as needed and charts are reviewed periodically by the chief and the home care doctors to provide the supervision and interest without which patient care may tend to become routine and lackadaisical.

Patients are taken on only if they meet the eligibility criteria: not so sick as to require daily attendance by a physician, but sick enough to require a physician's visit at least once every two weeks. Our patients represent about 25 percent of the ordinary ward population of general hospitals, with diagnoses ranging from heart disease and arthritis to terminal cancer.

(Continued on the next page)

Below: (l. to r.): Mary M. Ferry, R.N., president-elect, Vermont Hospital Association; William K. Turner, president Rhode Island Hospital Association, and Mary L. Turner, wife of William Turner.

Captured at a bright moment at the New England Hospital Assembly reception were (l. to r.): Dr. J. R. Mcgibony, director of programs, Hospital administration, University of Pittsburgh; Oliver G. Pratt, past president, N.E.H.A., executive director, Rhode Island Hospital, Providence, R. I.; Larry Lermond, representative of Wilmot-Castle Company, and Douglas West, hospital program director, United States Public Health Service, New York City.

Above: At the banquet in the Georgian Room of the Hotel Statler are shown (l. to r.): Mrs. William L. Wilson, wife of the past president, New England Hospital Assembly, and Mrs. Richard Viguers, wife of the new president, New England Hospital Assembly. The ladies were photographed on their way to the speakers table.

Below: After viewing the education exhibits on the mezzanine floor an administrator, his wife and his secretary decide to take a break. Shown below (l. to r.): Albert L. Beaulieu, administrator, Sceva Speare Memorial Hospital, Plymouth, N. J.; Mrs. Beaulieu; and Helen K. Inkell, secretary to Mr. Beaulieu.

The home care physicians have responsibility for a fixed number of patients. Nursing service is provided through the Visiting Nurse Service of New York. Social service is provided by full time social workers of the home care department. Physical therapy is used as indicated, and occupational therapy of some sort for almost everyone on the program. Drugs, equipment of all kinds, oxygen, bandages and dressings are provided; housekeeping is provided to a limited degree if it makes it possible to take a patient home who would otherwise have to remain in the hospital. When necessary, the patient is returned to the hospital where he has a priority admission. A patient can be taken into the hospital by ambulance for x-rays, special laboratory work or even surgery, and returned home by ambulance. Many procedures like blood transfusions, paracenteses, and so on can be done in the home with proper care and assistance.

The home care program gives evidence that organization of hospital medical services can be used extramurally.

Geriatrics—Statistics, Present and Future

Joseph Tansey, M.D., Associate Medical Director, John Hancock Life Insurance Co., Boston—The progress of medicine over the past several decades has added years to life expectancy. To use these years to greatest advantage is the problem facing the medical man, the economist, the sociologist and the entire community.

The objective of medicine is to attack the problem of degenerative diseases. The economist and political scientist can make certain that proper use shall be made of the older citizen who is still capable of productive work. For those unable to participate in the labor force because of disability, a decent income should be available, either through social security, private pension plans or savings.

The sociologist must play a leading role in helping older people make the adjustments that are necessary. More thought needs to be given to housing for old people as well as to solving the problem of loneliness and frustration.

A coordinated approach on the part of everyone concerned is greatly to be desired—a community organization of public spirited citizens who will interest themselves in the needs of the aged and who will demonstrate how much can be accomplished.

The Trustee—the New Member and His Future

George S. Stevenson, President, Grace-New Haven (Conn.) Community Hospital—It is important to guide the development of a new member of the board in such a way that he will become an effective member of the team. Of all the qualities he will need to cultivate I shall emphasize one—understanding, and shall treat it from the standpoint of what veteran trustees can do to assist him.

First he will need to be instructed in certain generalities, such as: the broad concept of hospital functions, the organizational chart, the extent and boundaries of his responsibility and authority as a trustee. At an early day he will be conducted over the entire plant so that he can see it as a whole, observing what goes on in each area and the relation of each to the others.

Next he will be ready for a committee assignment. As he is called upon to help make actual decisions he will get the feel and touch of the manifold processes, and will be on his way to understanding. Understanding, to be useful, must lead to action. Action gives us the straightest and broadest road to understanding.

If the new member can be rotated from one committee to another his progress along the road to a constantly broader and deeper understanding will be speeded.

Trustee-Administrator-Staff Relations

Leland McKittrick, M.D., Massachusetts General Hospital, Boston—The hospital is a community effort. It is not built for physicians, the administrator or the governing body to do other than to give the people the highest possible quality and quantity of medical service.

The governing body is responsible for all aspects of hospital work—its financial stability, its medical care and the services which it renders. Rarely, however, does a governing board have the medical background to make the necessary decisions in the medical aspects of hospital work. It is, therefore, dependent upon the advice and recommendation of the medical staff.

The medical staff must appreciate the responsibilities, privileges and problems of the governing board, and it is important for the lay members of a governing board to understand something of the background and thinking of the physician. The physician looks upon the hospital not in the usual employer-employee relationship, but rather as one in which he joins with the hospital in a mutually advantageous arrangement through which those coming to the hospital may be assured certain essential medical services. If the physician lives and practices an ethical and moral life, he expects to continue indefinitely with what he is doing. If by chance he thinks he is unfairly dealt with by his colleagues or his hospital, he wants some mechanism of appeal whereby he can feel reasonably sure that he will have fair play.

Basically, whether you are a hospital administrator, a member of the governing board or a physician you will understand each other and be willing to try to understand the philosophy behind the attitudes and problems which each of you must face; then, as honest, intelligent people, you can reach common agreement.

Essential to a complete understanding is a continuing liaison between the staff and the governing body. We must recognize the differences which may develop between them; the closer the relationship between the medical staff and the administrative body, the more complete the understanding and the fewer the problems.

Hospital Relationships—A Challenge to Physicians and Hospitals

Albert W. Snoke, M.D., Director, Grace-New Haven (Conn.) Community Hospital, Chairman, AHA Council on Professional Practice—It must be accepted by all those associated with hospitals and medicine that the eventual pattern of medical care in this country will be determined by the demands of the consumer—the public. Many of the requirements of the public are readily identified, but there is question as to whether most physicians, hospital administrators, and hospital boards appreciate what trends and demands are developing and how they might affect the existing pattern of hospital and medical care.

Future medical and hospital care in this country will be profoundly affected by social or public requirements such as prepayment insurance, comprehensive and combined medical and hospital care, employer responsibility for cost of health insurance, preventive medicine and diagnostic facilities, standards of hospital and medical care and education in the health professions.

Hospitals are dependent upon good physicians for the establishment and maintenance of adequate standards and for proper medical care to patients. Physicians are dependent upon good hospitals for the provision of adequate facilities to diagnose and treat their patients.

The new demands of the public call for health care through health insurance. Group practice can only be met by hospitals and physicians working together. The voluntary hospital is one of the greatest single factors for the preservation of voluntary medical practice.

Above: (l. to r.): Sister St. Hilda, R.N., Villa Muir Rest Home, Bay View, Saco, Me., talks with Sister St. Fernand, R.N., St. Andres Home and Hospital, Biddeford, Me.; and Sister Marie Carita, R.N., also of Villa Muir Rest Home.

Above: Pictured at the reception for officers and trustees are (l. to r.): Elsie MacKenzie, nurse anesthetist, Brockton (Mass.) Hospital, and Mrs. Thomas J. O'Leary, president, Ladies of Charity, Carney Hospital Auxiliary, Boston.

Below: Carl W. Walter, M.D., Peter Bent Brigham Hospital, Boston, gave an instructional conference on the Operation of the Central Supply room. He is pictured above with one of his students, Kathleen Norman, Westminister Hospital, London, England. Miss Norman is on a four-month scholarship to study nursing in hospitals in the United States and Canada. She is currently at Peter Bent Brigham Hospital.

induction is rapid...anesthesia smooth...recovery prompt
and side effects infrequent and mild with **SURITAL**® sodium
ultrashort-acting intravenous anesthetic

Detailed information on **SURITAL** sodium (thiamylal sodium, Parke-Davis) is available on request.

MEDICAMENTA VERA · PD CO. ·

PARKE, DAVIS & COMPANY DETROIT, MICHIGAN

American Academy of General Practice Meets in Los Angeles

One hundred thirty-nine hospitals have launched general practice residency programs since 1948, physicians attending the seventh annual scientific assembly of the American Academy of General Practice were told by Academy executive secretary Mac F. Cahal. These hospitals offer 541 approved general practice residencies.

Hospital general practice sections increased 50 percent from 1950-53, although there was only an eight percent increase in the number of general hospitals, according to Ivan C. Heron, M.D., San Francisco, chairman of the Academy's board of directors.

Important action taken at the assembly, which met in Los Angeles March 28-31, included:

- Approval by the Congress of Delegates of a recommendation that hospitals give every patient on dismissal a formal statement indicating exactly what procedures each doctor performed on him—in order to eliminate "ghost surgery."
- Dropping of 241 doctors from membership, because they had failed to complete the 150 hours of approved postgraduate study required for renewal of membership, which expires every three years.
- Announcement of the recent authorization of a new nationwide television program which will illustrate and describe the professional and public service activities of general practitioners.

Abstracts of some of the papers follow.

Formula for Continued Public Acceptance Of Voluntary Medical Care System

William B. Hildebrand, M.D., Menasha, Wis., President, American Academy of General Practice—Continued public acceptance of our voluntary system of medical care depends upon a simple formula:

(1) We must graduate enough well-trained doctors of medicine for our nation's needs.

(2) These doctors must be equitably distributed.

(3) There must be a proper ratio of general practitioners to specialists.

(4) Medical care must be adequately given at a price the public can afford.

(5) Mutual understanding and confidence must be reestablished between doctor and patient.

I believe the Academy can help put this formula into operation by adopting these four proposals:

(1) Recent medical school graduates should be required to present more postgraduate training for membership consideration.

(2) More hours of postgraduate training should be required for continuing membership.

(3) Future membership applicants should be screened more carefully.

(4) Some effective blueprint should be drafted for disciplining and censuring members who have forgotten or neglected their professional responsibilities.

Operation Saves Legs Of Diabetic Patients

Alton Ochsner, M.D., Chairman, Department of Surgery, Tulane University, and Director of General Surgery, Ochsner Clinic, New Orleans—We have perfected an operation which will save 75 percent of the gangrenous legs of diabetic patients.

In the last six years about 500 diabetics have undergone the operation, which involves a delicate nerve-cutting procedure.

(Continued on next page)

New Chemicals Effective Against Pinworms

Thomas S. Bumbalo, M.D., Buffalo, N. Y.—Pinworms, believed to infest 18,000,000 victims in this country alone, can be wiped out with a new group of chemicals—salts of a complex substance called piperazine.

The substance has been used successfully in 91 percent of a large group of patients.

Overactive Parathyroid Glands May Cause Kidney Stones

R. G. Sprague, M.D., Professor of Medicine, Mayo Foundation, University of Minnesota Graduate School, Rochester, Minn.—Approximately five percent of the kidney stone cases seen by physicians are due to overactivity of the parathyroid glands.

Overactivity of these glands, usually caused by one or more tiny tumors which must be removed surgically, leads to an increase in the amount of calcium and phosphorus in the urine, a condition which favors the formation of kidney stones.

Operation on Pericardium Gives Hope To Heart Disease Patients

M. S. Mazel, M.D., Chief Surgeon, Edgewater Hospital, Chicago—A relatively safe, simple operation on the pericardium offers new hope to many heart disease patients. The operation takes only 30 minutes, and the patient may get up the following day.

The pericardium is opened and any fluid removed. The sac is then partially filled with a very fine silicon powder which is spread, with special instruments and atomizers, between the heart and the pericardium.

The operation causes a severe inflammatory reaction which, however, is not infectious. This reaction increases the number of blood vessels near the heart, pericardium, and surrounding organs. They bring a new supply of blood to the heart.

Surgery must be performed before the patient's heart is damaged beyond repair.

Accidents Kill 12,000 Children a Year

Julian P. Price, M.D., Florence, S. C.—One in three deaths in children over one year of age results from an accident or accidental poisoning. Each year 2,000,000 children are involved in accidents which require medical attention. About 12,000 die, and another 40-50,000 are permanently crippled or disabled.

The doctor should give specific instructions on the use of drugs prescribed. "A spoonful as needed" may be enough the day the drug is prescribed, but a month later the mother may have forgotten what the drug is for, and what size spoon to use. Too many medicine closets are jammed with half-filled bottles.

Every doctor's office and every hospital emergency room should have a good textbook on traumatic surgery and reference books which discuss the common household items which might be involved in poisonings.

Urges Medical Investigation Of Unexplained Deaths

Charles P. Larson, M.D., Assistant Clinical Professor of Pathology, University of Washington, Seattle—Public-minded doctors should play a more active role in investigating unexplained deaths.

If all coroners were physicians and had ready access to specialists in forensic pathology and allied police science, we would have an excellent medicolegal system.

If all the 2,000 certified pathologists practicing in the United States were engaged solely in forensic pathology, we could doubtless have the finest national medicolegal investigative system that could be devised.

This is obviously not feasible. However, I believe that, with a few geographic exceptions, there are enough well-trained pathologists, were their talents properly utilized, to investigate competently all unexplained deaths.

It will be many years, of course, before we can change legislation in all our states to permit this Utopian state of affairs. In many states, coroners hold office under the state constitution. But the sooner doctors become aware of the situation, the sooner the situation can be corrected.

Everyone Likely to Have One Bone Fracture

Harold E. Crowe, M.D., Chairman, Surgical Committee, Los Angeles Orthopaedic Hospital, and Chief of Orthopedic Surgery, Methodist Hospital of Southern California, Los Angeles—Every American probably will suffer at least one bone fracture during his lifetime, thanks to the modern machine age, violent sports, high speed travel, and increased life expectancy.

The type of fracture best treated in the doctor's office is the very common fracture of the neck of the humerus just below the shoulder, occurring most frequently among older people. Such fractures usually can be moved into satisfactory position without anesthetic or hospitalization. Treatment by the application of a sling from neck to wrist, with motion beginning in the first 24 hours and practiced two or three times a day in the dependent position, should result in the patient's recovery in from eight to 12 weeks.

Allergic Reactions Usually Start When Substance Enters Nose

Nathan E. Silbert, M.D., Lynn, Mass.—Most allergic conditions start when the substance causing the reaction enters the nose.

The story of the patient's life will almost always provide clues to the cause of the condition.

Antibiotics are recommended for most bacterial causes; intramuscular injections of trypsin to loosen solidified mucus; antihistamines for relief of sneezing; vitamins, minerals, and polyunsaturated fatty acids to build up resistance; vaccines are recommended for use against many specific irritants.

Child May Not Want to Hear

A. Bruce Graham, M.D., and **J. Lewis Dill, M.D.,** Henry Ford Hospital, Detroit—The child who doesn't seem to hear, or who doesn't learn to talk, may not be deaf—he may not want to hear.

The mentally retarded child may appear to be deaf, but actually sounds and speech neither interest him nor attract his attention. Aphasic children, in the brain-injured group, may have perceptual disturbances which makes sounds and speech confusing. As a result, the child learns to avoid them and is soon labelled deaf. A third group of children are so emotionally disturbed and withdrawn that they too appear deaf.

The child's education should not be planned without knowledge of the cause of his hearing difficulty.

ORDER NOW!

save your institution as much as $170.00 per 5000 tablets†

PURCHASE Serpasil®

(reserpine CIBA)
TABLETS

IN BOTTLES OF 5000

SERPASIL is the *Number One* prescription product in its field. NEW indications for this versatile tranquilizing and antihypertensive agent *mean more new prescriptions in your pharmacy.*

Be prepared to meet the increasing demand and save hundreds of dollars for your institution by filling out and mailing the attached card today.

†Based on the cost of 5000 SERPASIL Tablets, 1.0 mg., purchased in bottles of 5000, compared with the cost of a similar purchase in bottles of 100 tablets.

FIRST CLASS
PERMIT NO. 157
SEC. 34.9 P. L. & R.
SUMMIT, N. J.

BUSINESS REPLY CARD
NO POSTAGE STAMP NECESSARY IF MAILED IN THE UNITED STATES

VIA AIR MAIL

5c. POSTAGE WILL BE PAID BY

CIBA Pharmaceutical Products Inc.
556 Morris Avenue
Summit, New Jersey

DEPT. 109

save

order today

For even greater $avings

Mail the attached card for quotations on BULK PURCHASES

Serpasil

Tablets / Ampuls / Elixir

mail this card today

REPLY CARD Please send me at once a quotation on the following **SERPASIL** items:

_____ M SERPASIL Tablets (0.1 mg., 0.25 mg., or 1.0 mg.)
Quantity

_____ x 50 SERPASIL Ampuls, 2 ml., 2.5 mg. per ml.
Quantity

_____ Pints SERPASIL Elixir, 0.2 mg. per 4 ml.
Quantity

Name of Institution (Please Print)

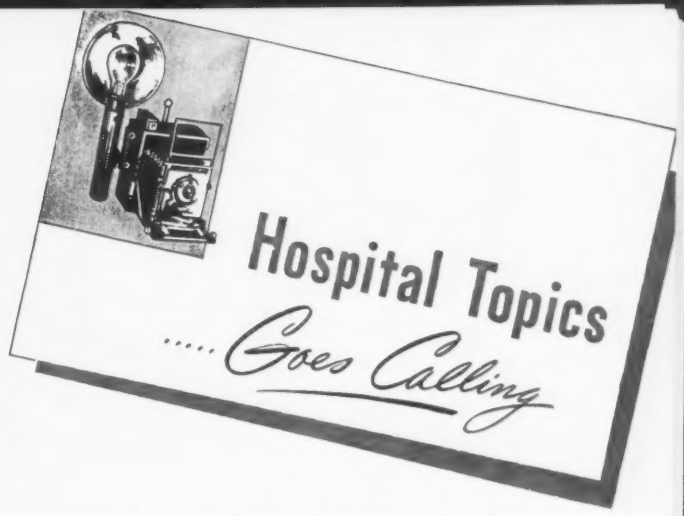
Address

City Zone State

Signature of Authorized Person

3/7827

Above: Child in wheelchair looks over books in one of the attractive rooms in the children's division. Hospital at present admits only cerebral palsied children between the ages of six and 16.



. . . on the Bird S. Coler Memorial Hospital
Welfare Island, New York City

● Keynote of the patient-centered rehabilitation program at the Bird S. Coler Memorial Hospital on Welfare Island, New York City, is concern for the patient's total rehabilitation—emotional and social, as well as physical—insofar as is possible within the framework of his particular disabilities. The 80 year old arthritic, for example, who laboriously propels his wheelchair down the length of the corridor is looked upon not merely as a chronic, indigent, geriatric—a charity ward whose physical needs must be cared for—but as an individual with the innate right to remaining years as useful and meaningful as possible.

Out of this philosophy has evolved a medical-hospital team aimed at bringing about such rehabilitation to the highest degree possible.

Key figure in the team is the physician. Through him is channeled the care-plan and treatment prescribed by each of the other members, which include specialists such as physical therapists, psychologists, orthopedists, speech therapists, and others, depending on the requirements of each particular case.

The system works as follows: When the patient is admitted to the hospital he is first given a thorough physical examination by the phsyician, who makes a diagnosis of his general, overall physical condition. Throughout the patient's entire hospital stay, a close physician-patient relationship is maintained. Next, the patient is successively visited by the other team members who examine him from the viewpoint of their particular specialty. The psychologist looks for such things as the patient's mental state—is his attitude one of hopelessness and depression? Is he detached and withdrawn? Does he have a personality problem which may handicap him in responding to treatment; and so on.

The physiatrist evaluates him in terms of how well he is able to function physically; what his disabilities are, and what kinds of treatment and exercise he will need. A vocational therapist determines the possibilities of the patient's returning to his former vocation, or developing some other useful skill if this is not possible.

Team meetings, held twice a week, are the focal point at which members come together prepared to contribute a report on the patients in their particular area and to make recommendations to the physician. After each new

(Continued on the next page)

Below: Here is part of the Bird S. Coler Memorial Hospital. This hospital is part of the large New York municipal system of which Basil MacLean, M.D., is Commissioner, it is affiliated with the New York Medical College. A new four story structure is nearing completion which will provide extensive ancillary facilities as well as research laboratories.

Above: Patients working in the sewing room where clothing such as pajamas, bathrobes, etc. is repaired. Room contains 47 sewing machines as well as special machines for making buttonholes, etc. Patients who work in this room are paid a small salary.

Above: Nurse in the cerebral palsy division helps a young patient do arm exercises by playing a hockey game with her. At present there are 20 children at Bird S. Coler.

Below: A hemiplegic patient exercises leg and foot muscles on a bicycle built especially for this purpose. Through the windows he can watch the busy river traffic on the East River. Wheel shown at left is for muscle strengthening exercises.

patient has been thoroughly discussed, the physician gives his medical opinion and prescribes a course of treatment for all team members based on their recommendations.

The majority of the patients are chronics referred from other hospitals after they have passed the acute phase of their disease. Eventually the majority of the patients are able to leave the hospital for lives of varying degrees of social or economic independence. Others, mainly geriatrics, must remain in the hospital the rest of their lives. For both types, therapy and activities are aimed at developing a social outlook which will enable them to relate themselves in a constructive spirit of cooperation and friendliness with others. Philip J. Kahan, M.D., medical superintendent of the hospital, firmly believes this to be a most important factor in any chronic or geriatric rehabilitation program. In the interest of such a program of social rehabilitation the two-year old hospital was designed to include many outstanding facilities, among them a beauty shop, a barber shop, chapels, a little theater auditorium, and many others.

Crafts taught in the occupational therapy department are designed to be useful as well as therapeutic. Because the medical team feels an important part of therapy is a feeling of vocational usefulness and productivity, patients in some of the workshops are paid small salaries. This not only bolsters morale, but provides them with spending money for small necessities or gifts, and for special treats in the canteen where refreshments and notions are sold.

The location of the hospital—Welfare Island, in the middle of the East River—in itself is of therapeutic benefit. Windows on both sides look out on busy river-boat traffic against a background of Manhattan skyscrapers. Sloping down from the hospital to the river's edge is a spacious lawn handsomely landscaped.

The interior of the hospital successfully combines the utilitarian with the colorfully attractive. Corridor walls are of shiny green tile, easily kept clean and glistening. Upper walls, acoustical ceilings and rubber tile floors of variegated shades of rose-rust, form a pleasing color combination with the green tile.

A pictorial review of some of the outstanding features of the hospital is presented on this and the following page.

Above: A patient in the print shop is shown operating a printing press. This man spends much of his time printing signs for the hospital, notices for the bulletin boards, etc.

Below: The hospital contains three chapels—Protestant, Catholic and Hebrew. The Hebrew chapel is pictured below. Chaplains for each faith conduct regular services for the patients.

Above: Patients look at television in one of the sunny day rooms in the hospital. Note the pretty flowered wallpaper and the draperies; colors are bright and cheerful. Color is used in the wards, also, and each patient's bed, night table, etc. is placed in a separate cubicle so that he has some measure of privacy.

Right: Joseph Chase, OTR, shows a cutting board made by patients in the prevocational clinic. Purpose of this clinic is to help determine the type of work patients will be capable of doing in the vocational field.

Spiritual Preparation of the Surgical Patient

By Rabbi Ferdinand M. Isserman
Temple Israel
St. Louis, Mo.

• *Here is another program speaker's paper from the Second National Conference of Operating Room Nurses held in St. Louis in January.* HOSPITAL TOPICS *will bring you more papers from this convention in succeeding issues.*

• That a group of professional women, dedicated to the ministry of healing, and specializing in a field allied to surgery, should schedule an address on the spiritual preparation of the surgical patient by a member of the clergy, is indicative of a welcome change of mood.

A generation ago the overwhelming majority would not have been sensitive to the relationship of a spiritual ministry to physical healing. The clergyman's presence at the bedside of a surgical patient was sometimes tolerated as a necessary nuisance, and because of public relations there would have been no overt expressions of hostility toward him. It was an age which had been swept off its balance by the remarkable discoveries of science in which medicine had profoundly benefited.

The great advances in medical diagnosis and in the art of surgery, due to chemistry and technology, the remarkable results achieved in immunization against disease, by the use of new drugs, and the complete conquest of hitherto incurable ailments, swung the intellectual pendulum of many to the view that illness was entirely a physical manifestation which could be successfully combated exclusively by physical media.

For some time now, the pendulum has been swinging in the other direction, and of recent years leaders in the field of medicine have even assumed the initiative in pointing out the emotional and spiritual factors which cause physical ailments.

Psychiatry and psychosomatic medicine have taught professionals and laymen alike that physical illness involves a total personality pattern which may have emotional and spiritual as well as physical causes. Never was this better expressed than in this incident which involved the late Dr. Lawrence Goldman, in his time one of the busiest pediatricians in St. Louis.

Dr. Goldman received a call from a local hospital one evening, asking him to appear at once in the operating room, where emergency surgery was to be performed on a Boy Scout who had become ill on the plane while on his way from Detroit to some Scout function in the far West.

Attired in evening dress, ready for the symphony concert, Dr. Goldman entered the operating room, expecting to be free in a few minutes. The surgeon had not waited for his arrival and was about to complete the operation, when suddenly the boy's heart stopped beating. Everyone in the operating room worked frantically to bring back the life spark, but seemingly in vain.

When the surgeons had given up the lad for dead, Dr. Goldman, who was standing by, asked if he might see what he could do. For a full 45 minutes he continued with artificial respiration or other methods. One other physician remained with him. At the end of that time the heartbeat returned. The boy's life was saved, and subsequently made a full recovery.

The boy's father, a titan in the automobile industry, heard that Dr. Goldman's refusal to give up was responsible for the life of his son. After the boy's convalescence the father came to see Dr. Goldman in his office and said: "I am a very rich man. You have saved my boy's life. Here is my signed check. Fill it out for any amount that you wish." Dr. Goldman returned the check and said: "You are mistaken. I did not save your child's life. God saved his life."

It is this new mood of humility, involving recognition of the limitations of physical science, which Dr. Goldman expressed, and which now characterizes large numbers of the medical and allied professions.

Today many physicians recognize that man is body and soul; that healing involves the total man, his spiritual as well as his physical hurts. Just recently we in St. Louis had an example of the triumph of the spirit over the flesh. Father Daniel Lloyd, a member of the Jesuit order, a man of exceptional talent, learned some time ago that he had incurable cancer and that his death was a matter of brief time.

He took the sad news in stride, carried on his work as if death were not around the corner, calmly wrote his reactions, and showed the capacity of the spirit of man to triumph over death and over the ailments of the flesh. Undoubtedly an awareness that the soul played a part in the healing processes moved your leaders to place the subject, "The Spiritual Preparation of the Surgical Patient," on your agenda today.

Though I have been in the ministry now for almost 33 years, I was so challenged by your subject that I determined to confer with my colleagues in the clergy, to find out what they do, what their experiences are, and what insight they have gathered about this subject.

I sent out a questionnaire to roughly 125 clergymen, most of them Protestants, some of them rabbis and some priests. The names were selected from the list in my office representing at least a dozen different Protestant denominations. When I began to analyze the questionnaires, I had received 75 responses. Since then at least 10 more have drifted in to make a total of 85 out of 125. The more than two-thirds response indicates the great interest of the clergy in the subject and their readiness to share their experiences and their observations with you, through me.

Statisticians tell me that a better than two-thirds response to such a questionnaire, sent during the Christmas season when mail is heavy and frequently unanswered, is usual. Many of the clergy expressed the hope that I would send them copies of this paper. Others were glad that such a paper was being prepared for an audience of nurses. One even envied me my opportunity to speak.

I have found that most ministers, with few exceptions, regard service to their congregants at a time of crisis, such as a surgical operation, to be of the greatest importance. They recognize it to be a source of value to the patient, binding him more strongly to a religious philosophy of life and strengthening his loyalties to the church and to the minister. Most of them feel that the hospital authority is sympathetic, by and large. Especially is this true of the denominational hospitals, though equally so of many others.

Most clergymen also find the physicians sympathetic. Many of them are grateful to those hospitals which notify them of the admission for surgery of members of their congregation. A number wrote that they would welcome all hospitals giving them this information.

I would have assumed that in smaller churches the minister would be better posted about these personal events in the lives of his membership than in larger ones, but found that not to be the case. The minister of a church of less than 500 members writes that he frequently hears about these operations too late for him to be of any service. It may be that the better organization of larger congregation keeps the minister better posted. In some denominations, the family will make it a point to notify the minister when an operation has been planned. The ministers feel that there is an opportunity for them to be of great service to their people. They are anxious to render that service, and believe that they are of some help.

What do ministers do when they visit the patients before the operations? Some think that just their presence has a salutary effect. They symbolize for the patient his friends in the church who are concerned with his well-being. The minister is a reminder of a God who cares for and sustains him. Some will offer prayers at the bedside. A few will bring prayer books or Bibles. Many will leave devotional literature. Some denominations have gone to great pains to prepare such cards or pamphlets. As a result of this inquiry, I am recommending to my own national headquarters that they prepare such leaflets for distribution.

Above: Part of the A.O.R.N. convention group in the corridor after an interesting session on operating room procedure. They had time to view the scientific and technical exhibits before the next session.

Some will administer communion, not necessarily in anticipation of death, but as the choicest religious experience which their church can offer. Some ministers have regular kits which contain the necessary equipment for this rite, or thus prepare the patient for death as is customary with their denomination.

An individual who is prepared for death is calm, has no fears and can face any crisis with high spiritual courage, confident that no matter what happens to him he will be welcome by God.

One minister wrote that he finds holding the hand of a patient or placing his hand on the patient's forehead to be significant and helpful.

Most ministers do not remain during the operation, especially if a large family or many friends are present, and also perhaps because the pre-surgical preparation may involve the administration of opiates, and the length of the operation may be unpredictable. Only in exceptional circumstances do ministers remain with the family to await the end of the operation. When death is a possibility, they will remain to give the family strength.

In response to the question of whether or not they discussed the operation with the patient, the usual answer was yes, if the patient inaugurates the discussion, or if they have previously discussed it with the surgeon. Some wrote that it is good to let the patient talk about the operation. Many stated that they strengthened his confidence in the technics of surgery, in the skill of the surgeon, and in the laboratory facilities. Patients know that ministers have frequent calls at hospital, and that their familiarity with hospital technics makes it possible for them to assure the surgical patient that he's in good hands.

(Continued on the next page)

Above: At the recent A.O.R.N. convention in St. Louis D. V. Thomas (l.), representing American Cystoscope Makers of New York City, converses in the coffee lounge with Emma Landers, R.N., Emory University Hospital, Atlanta, Ga., and Dorothy Whitlow, Burlington (Ia.) Hospital.

SPIRITUAL PREPARATION OF THE SURGICAL PATIENT continued

One minister found that nurses at times are embarrassed when he commences a service. This embarrassment may be due to the fact that the nurse feels that she is not wanted, or that she is of a different persuasion, or does not want to share in other religious ceremonies, or that this service is to be an intimate personal experience in which she might appear to be an intruder. This minister suggested that it would be helpful if nurses would simply take the service for granted, creating an atmosphere without any tension, being fully at ease, assuming that this is normal in the hospital, and should cause no undue alarm to the patient.

In response to the question of whether or not the family desires the presence of a minister, the answers vary. As one minister wrote, the pastoral ministry is an art. Every person is different and reactions will vary. One clergyman answered, "Where the minister is a frequent visitor in the home, present on all occasions, the patient just takes it for granted that he should be present in a time of crisis. The minister is part of the family, and if the family is there he is also expected."

Where the minister has no such relationship with the family, his presence on the eve of an operation may tend to intensify the sense of crisis or to multiply the tensions. A few ministers who serve, it seems, the more sophisticated congregations where church attendance is not regular and where many members appear to worship only on special occasions, wrote that among these groups the family regards the appearance of the minister as an evil omen, almost as a precursor of death. "She is not so sick that she needs a clergyman," goes the thought.

Ministers think, however, that even though the family feels that way, the patient at such time welcomes a religious ministry. Even nonbelievers who may not have prayed for years will yet welcome the spiritual strength they may receive from their revived faith in God.

One minister wrote that a well-known agnostic clung to his hands in grateful appreciation for a blesisng. With active church people and believers, the presence of the minister certainly is most welcome. As one wrote, "To appear then means never to be forgotten."

What is the carry-over of such religious experiences with patients at a time of crisis? Do they become religious subsequently? Will they visit the church or temple more frequently? A few ministers replied that those who were lax tend to become more regular, or that the gratitude for recovery will make them more devout, or lead them more frequently to worship. Most of them find, however, that their visits have no effect as far as participation in public worship is concerned. One writes that it is one of the great disappointments of his ministry that the people to whom he has given much of himself in the times of their greatest crises do not respond to his greatest hope for them by participating more frequently in the spiritual fellowship of worship.

I asked what the effect of the minister's visit was upon the patient. I tried to divide the answers on the size of the church membership, but I found from the following that the response was the same. Some of the answers were:

"The patient said, you give me a boost."

"My visit built up confidence in doctor and nurses."

"Inner peace and calm, for God gives added strength and courage."

"The visit bolstered morale and relieved tension."

"Intensified faith in God's care and the surgeon's skill."

"Loneliness is a great ordeal, and the minister's presence dispels that."

"Religious faith and clear conscience aid recovery."

"The visit gave the patient confidence and comfort."

"He (the minister) helped to establish a contented, relaxed emotional situation in which physical healing can be most expeditious."

"Makes the patient feel at ease because God is with him."

"The pastor's presence undergirds his (the patient's) confidence because he has assurance that the family and the church are with him."

"He brings the presence of God, boosts morale, leads to trust in God and surgeon, and helps to provide the right mental attitude."

"One patient said: 'I do not know what I would have done without your visit. The healing power of faith brings miraculous results. The visit was helpful to the mind, the body and the spirit'."

"The visit inspired confidence and faith, and gave reassurance and steadiness."

"It (the minister's visit) overcame loneliness, homesickness, and even physical distress."

"Before the operation it (the visit) quiets the patient; afterward it facilitates convalescence."

"It helps to place himself trustingly in the hand of Almighty God, and to the saving power of the good physician."

"The visit dissolved fears, strengthened faith, and brought a personal touch to an impersonal situation. It inspired the patient with a greater confidence in God and His healing and sustaining mercy, and in the skill of doctors and hospital personnel. It helped the patient to accept the operation; overcame his suspicions and fears about it."

"The patients are angry with God because He has afflicted them with ailments; the reactions will vary with the faith of a patient. Compassionate regard is a source of strength and courage; the minister, the vehicle of God's grace."

"The fellowship of common concern is helpful. It focuses attention on the source of strength and helps patients draw on their own inner resources available at the time of need."

"It reminds the patient that God cares and suffers with him."

"It routs fear and builds courage, brings peace and hope and fortifies the patient with assurance and courage."

"The spiritual value of being prepared for death is a tremendous aid in recovery. It allays fear, deepens faith, helps the patient to know the presence of God as a reality."

That's how the answers go. Thus do the ministers indicate that they have faith in the value of such a ministry to the surgical patient; that they welcome the friendliness of hospital authorities who notify them, and that they have ample evidence that their ministry is helpful.

One minister reported that the patient cried during the prayer or blessing, and that the family members present were upset by the experience. Whether this expression of emotion is bad or good may be a matter of discussion. Afterward, the patient feels more reconciled and better prepared to face his ordeal.

Perhaps I should have sent a questionnaire to nurses and physicians to find out what their experience indicates about the value of a minister's visit on the eve of an operation.

I found—and this I would like to emphasize—that one of the greatest trials the patients face is the waiting period outside the operating room in large hospitals. All the calm the clergyman can inspire before the operation is dissipated by the long and uncertain wait where others are also waiting for their turn in the operating room.

While to hospital personnel this may be a routine matter, to a patient this is a most upsetting experience. If large hospitals with these long lines of patients waiting to be operated upon could eliminate this line, they would do a good deal for the calm of the patients.

In the questionnaire I inquired about the denomination of those who answered. I also inquired about the size of congregations. The answers were the same, from the ministers of the large as well as the smaller congregations. The reactions crossed denominational lines. People are people. They are made in the image of the same God. Despite denominational differences, they have the same hopes, the same fears, the same anxieties, the same yearning for love, the same hunger for companionship, the same desire for friendship in times of peril, and the same wish to be closer to God.

The rabbi, minister and priest visiting them bolster their morales. The technics used are largely the same. Where a denomination regularly prepares the patient for the hereafter, the preparation for death is helpful. Other denominations through their spiritual ministry give patients confidence in their own strength and resources.

All ministers were aware of the mechanics of hospital routine and anxious to comply with hospital regulations.

Here is another example of our common humanity which transcends creed lines. Many ministers expressed appreciation for the fact that such a paper was scheduled for this meeting.

Many years ago a great surgeon, near the end of distinguished career, had to submit to an operation which he knew well might prove fatal. But as he was being wheeled into the operating room, he sang to himself the old synagogue hymn he had known as a child and had sung with his parents: "God is with me. I shall not be afraid."

(Below is the questionnaire mentioned in Rabbi Isserman's article.)

QUESTIONNAIRE

The Clergy and the Surgical Patient

1. Are you informed when people in your church are to submit to a surgical operation? Yes___ No___
2. Do you see them before the operation? Yes___ No___
3. What is the attitude of the hospital authorities to your visiting patients there?
   Friendly_____ Indifferent_____ Hostile_____
   Comments_____
4. How is the family disposed to your visiting the patient?
   Friendly_____ Indifferent_____ Hostile_____
   Comments_____
5. What is the attitude of the patient to your visit?
   Friendly_____ Indifferent_____ Hostile_____
   Comments_____
6. What do you do? Do you pray with him? Yes___ No___ Do you bless him? Yes___ No___ Do you have any religious service? Yes___ No___
   Comments_____
7. Do you discuss the operation with your patient?
   Yes___ No___
   Comments_____
8. Do you bring the patient a prayer book? Yes___ No___ Do you bring the patient a Bible? Yes___ No___
   Comments_____
9. In what other ways do you bolster the morale of your patients?
   Comments_____
   _____
10. Do you stay with the family during the operation? Yes___ No___ Even if it is a long operation? Yes___ No___
11. How soon after the operation do you see the patient?
    Comments_____
12. In your opinion, what value does your visit before and after the operation have on the patient?
    Comments_____
13. How do the physicians evaluate your visit?
    Comments_____
14. After the operation, do you find people coming to church more regularly? Yes___ No___
15. Are there less than 500 members in your church? Yes___ No___
16. Are there less than 1,000 members in your church? Yes___ No___
17. Are there more than 1,000 members in your church? Yes___ No___
18. Is your church in the suburbs? Yes___ No___ Is your church in the metropolitan area? Yes___ No___
19. What is your denomination?
20. Your name (if you want to give it)_____
    _____
    (Name)
    _____
    (Church)
21. Please make ony other comments on this subject you wish to include that are not covered by the above questions.
    Comments_____

new hospital package

box of 500

CLINITEST® reagent tablets

BRAND

individually sealed in foil

Protected until moment of use

Hermetically sealed against moisture, *individually* foil-wrapped *Clinitest* Tablets cannot be harmed by warm, humid weather or by careless handling.

Convenient

Clinitest Sealed-in-Foil Tablets can be kept on hand for immediate urine-sugar testing for floor, ward or clinic use.

Economical

This new package makes possible the economy of quantity buying, together with the protection of *individual* foil-wrapping.

Waste is eliminated—tablets may be dispensed as required.

Clinitest Reagent Tablets Sealed in Foil—
Box of 500 (No. 2158) and
Box of 24 (No. 2157).

Order through your supplier

AMES DIAGNOSTICS
Adjuncts in Clinical Management

AMES
COMPANY, INC., ELKHART, INDIANA

AMES

Ames Company of Canada, Ltd., Toronto

59954

The Hospital's Role in Rehabilitation

By Heinrich G. Brugsch, M.D.
Physician-in-Chief, Rehabilitation Institute
New England Medical Center

Rehabilitation programs play an increasingly important role in the hospital of today, because chronic diseases and the consequences of accidents have created a major medical problem. Patients are admitted for a prolonged program designed to make use of faculties left after permanent damage has been done by illness or accidents.

Hospitals, by hiring the handicapped, could be very helpful in rehabilitating handicapped persons, since the ultimate goal of rehabilitation is future employment.

We have found at the Rehabilitation Institute of the New England Medical Center that handicapped workers can perform many different duties satisfactorily. We encourage many to seek employment outside the protective atmosphere of the Center—but often a job in the hospital is just what is needed to start them on the way to complete rehabilitation.

What kind of jobs can the hospital offer the handicapped? Some jobs are particularly well suited for them, such as the transcription of dictation on records. Other individuals may be selected for specific jobs—such as employment in the kitchen and maintenance department. There is no reason why epileptics cannot be hired, providing their attacks are controlled by medication and they are not in direct contact with the public.

Individuals handicapped by poliomyelitis are often suited for sedentary positions, such as information desk or secretarial work.

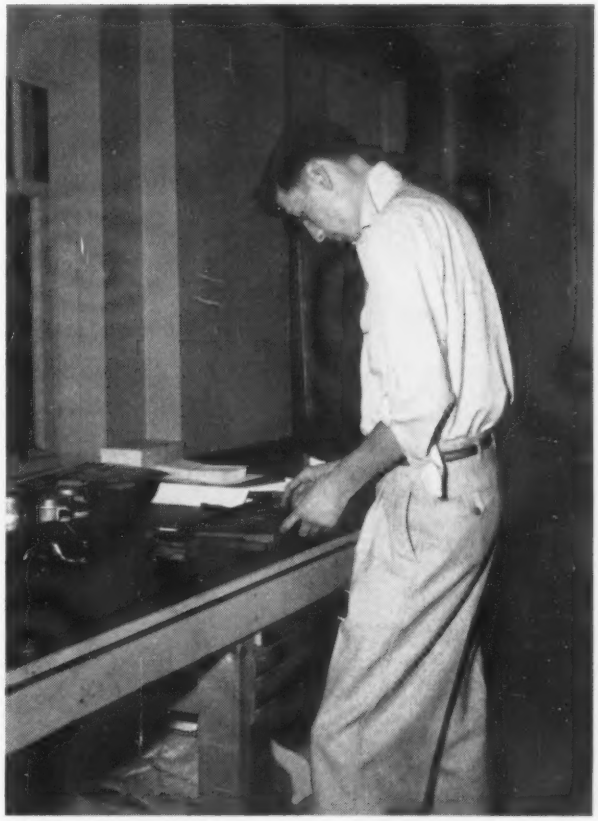
There are more opportunities available than meet the eye at first. We have at our institution about 20 handicapped employees, two blind, two severe polio victims, two epileptics, several with neurological disorders—all workers who give full satisfaction to their department heads. Good Will Industries, sheltered or community workshops, Sunshine Industries for the aged, and similar opportunities should be explored. The experiment of Viscardi, known as J. O. B. (Just One Break) to create industries manned entirely by the handicapped is worth watching. Boston is just now beginning to make efforts in this line.

Medical rehabilitation, according to the generally accepted definition, is the restoration of the handicapped individual to the fullest physical, mental, social, vocational, and economic usefulness of which he is capable. Obviously, the scope of rehabilitation services is tremendous. It must, therefore, in practice be limited by providing services for specific groups and excluding others. At the New England Medical Center the rehabilitation department does not accept the blind, deaf, mental cases, alcoholics, or drug addicts. Children are accepted only for certain diseases handled at the Floating Hospital, one of the units of the New England Medical Center. Others are referred to such centers as the cerebral palsy unit in Wellesley or institutions built for all forms of rehabilitation of children, such as the Crochet Mountain Rehabilitation Center in New Hampshire.

The size of a medical rehabilitation department is further limited by the practical considerations of economic management. The inclusion of beds as part of a general hospital is expensive and requires large expenditures for staff and upkeep.

A considerable saving can be obtained if the patients can be housed in convalescent units or near the center.

(Continued on next page)



Above: Ronald Simard, patient at the Boston Dispensary, is shown locking up a page form which will be transferred to a printing press. Vocational rehabilitation is an important part of the hospital's program; every effort is made to help patients find ways of earning their own living.

Above: A blind patient, Miss Alexander, works in the medical record library of the New England Center Hospital. The Center employs a number of handicapped workers, including several polio victims, epileptics, etc.

REHABILITATION continued

Such a unit has been added recently at the Institute. It has incorporated the principle of a dormitory, with nursing care at night and active participation in the rehabilitation program by day. Volunteers, such as members of the Junior League, contribute both money and labor to this program and are particularly helpful in providing a recreational program for the evenings.

The number of potential patients for rehabilitation all through the country is tremendous. William P. McCahill, executive secretary of President Eisenhower's Committee on Employment of the Physically Handicapped, recently estimated that jobs are needed by 30,000,000 handicapped Americans. It is difficult to establish the actual number of handicapped persons, because most disabilities are not reportable and many disabled are kept or keep themselves in hiding, either through the efforts of the family at home, in a nursing home, old-age home, or under pitiful conditions of subsistence from a public or private agency.

Every year 60,000 to 70,000 handicapped individuals are supported in part or in full by the Division of Vocational Rehabilitation. Many others, who are veterans, are taken care of by the Veterans Administration. But how small are these figures if we remember that annually more than a million people are injured in automobile accidents alone, another million suffer from orthopedic defects, such as cerebral palsy or poliomyelitis, and still another million live following a cerebral accident—sometimes with severe disability.

The recently inaugurated program of assistance for the totally and permanently disabled has shown that a large group of disabled persons consider themselves permanently disabled, while a review of the cases shows that a certain percentage can undoubtedly be salvaged.

Large communities provide services for handicapped suffering from certain specific disabilities—services often established with help of agencies—for example, the services available for crippled children and for victims of polio, tuberculosis, and alcoholism. In addition, large communities should have access to the hospital services of a department for physical medicine and occupational therapy, both the backbone of rehabilitation.

How such services should be consolidated and supervised by a person—usually an interested physician—depends upon the city and the spirit of its citizens.

Our services at the Boston Dispensary, a unit of the New England Medical Center, provide a challenge and an interesting experiment which is now three years old.

Below: This pleasant room has avocado green walls and blond wood furniture; patients gather here to read, talk or play cribbage as Melita Dawe (l.), is doing, with Arthur Gagnon (back to camera) and Louis Paciello.

The department has reached a certain stability in both the administrative setup and the physical planning, although the need for expansion is recognized.

The department was the direct outgrowth of an old, well-established massage clinic which was supervised by a man who spent considerable time and effort in the application of massage. With the growing interest of the hospital in chronic diseases, particularly arthritis, department reorganization became essential. This was carried out with two purposes: to establish a department which fulfilled the requirements of the American Medical Association, both in personnel and equipment, and to include facilities for rehabilitation for the inpatient in other units of the New England Medical Center, as well as the ambulatory patient.

The latter purpose was greatly helped by a gift which permitted setting up an occupational therapy department providing excellent facilities for carpentry, weaving, printing, and ceramics, as well as the creation of an exercise room with modern equipment such as hydraulic parallel bars, Delorme equipment for resistive exercises, etc.

Recently a kitchen was added, providing a teaching unit for the "work simplification" program established by the American Heart Association.

The department has now expanded to such proportions that we have added three physical therapists, one occupational therapist, a speech therapist, a vocational guidance counselor, and an administrator to the staff. All this was possible because insurance payments and agencies provide enough income not to burden the hospital administration unduly. At present we are still about $1,200 in the "red" every month, but the number of treatments has risen from 500 to about 2,000 a month and the number of patients from about 50 to 150.

Our service ranges from short-term treatments given to patients referred from outside or from the hospital to a complete evaluation with subsequent daily rehabilitation service, lasting sometimes over periods of three to six months. Obviously, such services are expensive, and the success and failure of a rehabilitation department as a whole, or of the individual patient, depends upon proper selection. The patient's underlying disease must be clearly established. Progressive diseases such as malignancy or progressive muscular dystrophy are usually not acceptable.

The patient must be cooperative and available. The latter is sometimes more difficult to achieve than the former. The patient must have enough stamina to carry out prolonged and strenuous forms of therapy. Thus, the younger the patient is, the better the chances to rehabilitate him.

Once the patient is accepted, the department has these essential functions, all carried out by members of its team:

(1) Physical and mental improvement. Various medical specialists work closely together. Individual cases—amputees, spinal injuries, paraplegics, or patients with severe arthritis—may require the services of the orthopedic surgeon, plastic surgeon, psychiatrist, and internist. With proper medical supervision the auxiliary professional staff, physical therapist, occupational therapist, and speech therapist will carry on the actual program of daily therapy.

(2) Information and help, provided by social service. This information helps place the patient's income, his family needs, and his immediate daily living problems, and also gives suggestions on how to finance the program of therapy, orthopedics, or prosthetic appliances, wheelchair gadgets, a new home, car, moving, or other needed expenditures.

(3) Recreational activities, including a supervised program of activities for daytime and evenings, extending from games to lectures and dances.

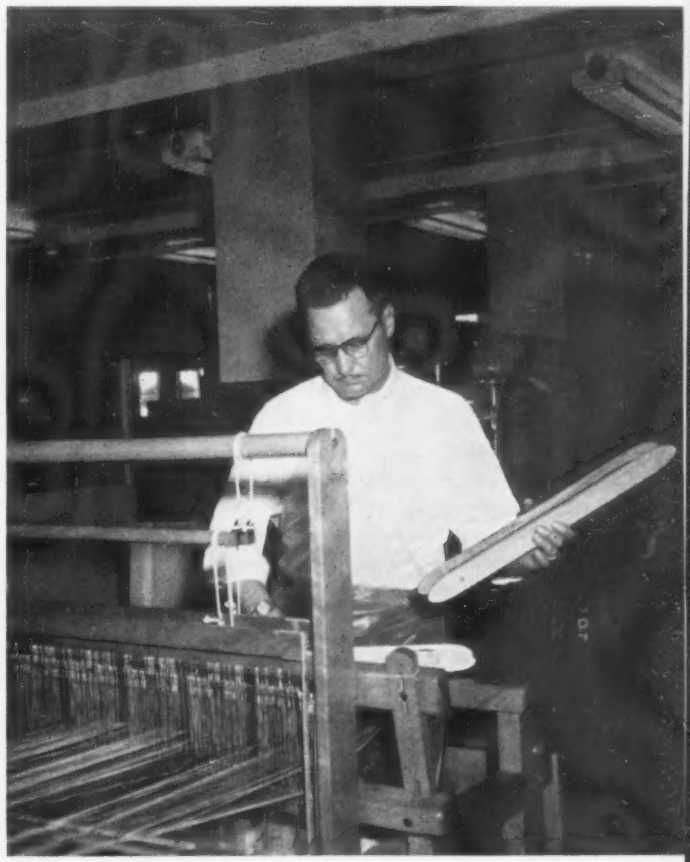
(4) Future employment. This phase is probably the least understood, most difficult phase of rehabilitation. It requires a preliminary evaluation of a patient's educational and vocational past, testing and retesting while under observation, innumerable conferences with the Division of Vocational Rehabilitation, employer, and patients, and often visits to plants, shops, or agencies.

The results of all this planning are often disappointing. The human factor, the deep, often subconscious desire by employers and even coworkers to keep handicapped out of sight, interferes greatly with placement. However, few phases in rehabilitation are so vital to the patient's morale as the visible signs of a regained independence—the pay check. Not all disabled will achieve full independence, but steps towards some future gainful occupation should be taken early.

The placement of the handicapped, his acceptance by society, and the best possible rehabilitation by his physician—those are goals which are not easy to obtain. But even if one out of 10 is taken off public assistance through return to work, he with his family, will repay in taxes within short months what communities and the state or federal government have expended for him over years, and will have to continue to spend for others less fortunate.

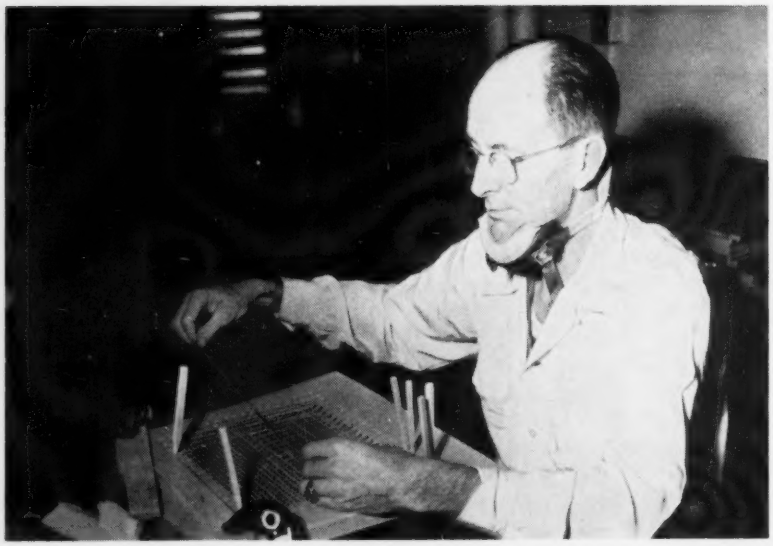
(Continued on next page)

Below: Arthur Gagnon operates a loom. Equipment in the Center includes weaving, woodwork, painting, sewing and other materials, for occupational therapy use.



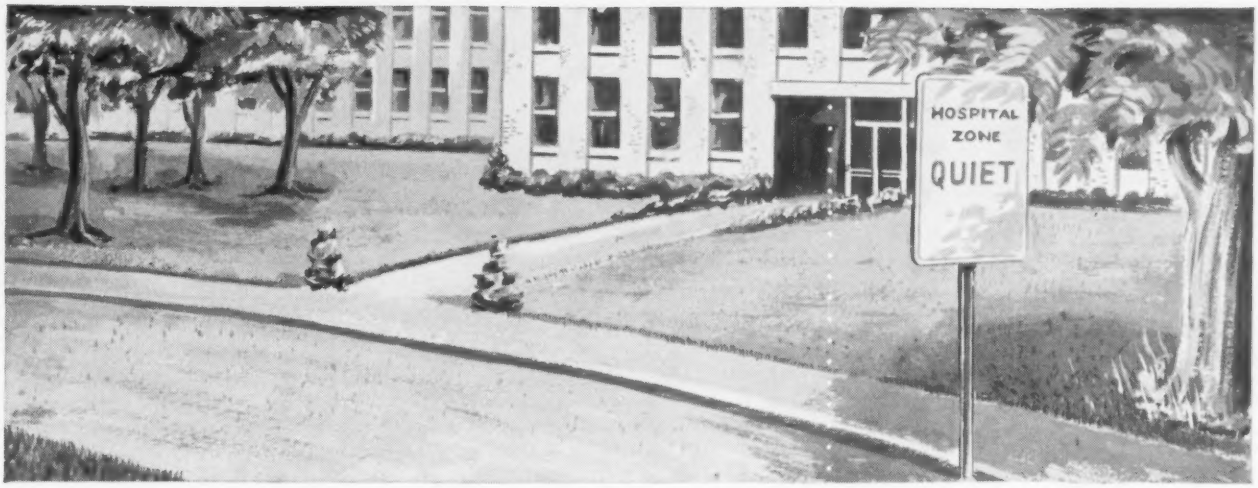
Left: An amputee learns the correct use of his new hand under the guidance of an Occupational Therapist. Medical students and graduates of Tufts College Medical School, and occupational therapy students from the Bouve-Boston School of Physical Education which is affiliated with Tufts College receive professional training at the Boston Dispensary.

Pictured at the right is a patient in the special self-help kitchen which combines fun with therapy. Here patients can fix their own snacks. This kitchen is new and is especially designed for disabled people. For instance, a wheelchair can be rolled right in under the sink for easier working and everything is within easy reach.



Medical Rehabilitation Service was begun in 1951 by the Boston Dispensary to offer the handicapped patient total medical care. Pictured at the right is a patient busy at work caning a chair. Rehabilitation includes medical evaluation, physical, occupational, speech, and diet therapy, prosthetic services, psychological and vocational guidance. A special Amputee Clinic has been included in the program since 1953.

In Appreciation



The great advances in the fields of hospital service and management have ranked among the most heartening developments of recent years. With modern hospital and medical care, Americans today enjoy better health than ever before in history. Hospitals are truly the health centers of their communities.

National Hospital Week makes all of us realize that our hospitals represent a form of security for healthy people as well as for those who are injured or ill. National Hospital Week affords the nation the opportunity to show its appreciation for the vital services performed by the men and women who make up the hospital team.

We in the health insurance business have enjoyed first hand acquaintance with the people who man the American hospitals, and we are proud to work with them. National Hospital Week has a great deal of significance for us and we honor the hospitals with real feeling.

On behalf of our policyholders and ourselves, it is a pleasure to salute all you members of the hospital team during Your Week for your fine tradition of public service!

The HEALTH INSURANCE COUNCIL

THE HEALTH INSURANCE COUNCIL IS AN ORGANIZATION OF INSURANCE COMPANIES WRITING HEALTH INSURANCE. THE COUNCIL EMBRACES NINE INSURANCE ASSOCIATIONS IN ITS MEMBERSHIP. THE COUNCIL SERVES THE HOSPITAL AND MEDICAL FIELDS AS A CENTRAL SOURCE FOR TECHNICAL AND PRACTICAL ASSISTANCE IN CONNECTION WITH THE DEVELOPMENT AND USE OF ACCIDENT AND HEALTH INSURANCE.

Detergicide®

Cleans... Disinfects... Deodorizes

...and costs less than 1.2c a quart

EFFECTIVE	Rapid action against common bacteria and fungae.
SAFE	A 1:4000 solution of Detergicide will not harm membranes of urethra or bladder. Contains no cresol, phenol, mercury, iodine, alcohol, hypochlorite or free chlorine.
TIME SAVING	Detergicide by its penetrating, emulsifying and detergent action reduces the time required for scrubbing and soaking.
NONCORROSIVE	Will not harm plastics, metals, rubber or glass. The powder contains a rust inhibitor. Recommended by maker of instruments with lens systems.
DEODORIZES	Detergicide actually removes odors.
CONVENIENT	Instruments in tray of Detergicide are always ready for immediate use.

Send for trial supply and literature.

C. R. BARD, INC.
SUMMIT, NEW JERSEY

Distributors for
United States Catheter & Instrument Corp.

Organisms Killed in 15 Minutes by Detergicide, in solutions shown at 20° C.

BACTERIA	
Pseudomonas Aeruginosa	1:3600
Proteus vulgaris	1:9000
Salmonella pullorum	1:11500
Shigella Sonne	1:11500
Klebsiella pneumoniae	1:10500
Streptococcus pyogenes	1:9000
Aerobacter aerogenes	1:8500
Escherichia intermedium	1:9200
Sarcina lutea	1:36000
Alcaligenes faecalis	1:39600
Streptococcus agalactiae	1:8500
Streptococcus salivarius	1:23900
Streptococcus mitis	1:79000
Micrococcus pyogenes var. albus	1:46000
Micrococcus pyogenes var. aureus	1:22700
Neisseria catarrhalis	1:79000
Escherichia coli	1:11800
Salmonella typhsa	1:29000
MOLDS and YEASTS	
Saccharomyas cerevissiae	1:1980
Streptomyces gedanensis	1:1480
Actinomyces gedanensis	1:1480
Trichophyton schoenleini (Achorion schoenleini)	1:1300
Trichophyton mentagrophytes (Trichophyton interdigitale)	1:1000
Microsporum audouini	1:1100
Cryptococcus neoformans	1:1300
Candida albicans	1:1480

These critical killing dilutions are not to be taken as dilutions at which detergicide should be used. Use only dilutions shown in instructions.

Detergicide, a highly concentrated form of benzalkonium chloride plus a non-ionic detergent, is available as a liquid; and as a powder containing a rust inhibitor.

POWDER — In a package to make 1 gallon. 50 packages per box.

LIQUID — Concentrate in bottles of 8 fl. oz., 16 fl. oz. and 1 gal. Only 2.5 cc makes 1 gallon.

Officers of the New Mexico Hospital Association, standing (l. to r.): F. O. McVey, administrator, Clovis Memorial Hospital, trustee; Homer A. Reid, director of administration, Lovelace Clinic, Albuquerque, executive secretary; Harry Miller, administrator, Memorial General Hospital, Las Cruces, trustee. Seated (l. to r.): Sister Agnes Rita, business manager, St. Joseph's Hospital, Albuquerque, treasurer; Elmer E. Zaudke, administrator, A.T. & S.F. Hospital, Albuquerque, trustee and immediate past president; Sister Mary Assunta, business manager, St. Vincent's Hospital, Santa Fe, president; Phil Carter, administrator, Bataan Memorial Methodist Hospital, A'buquerque, president-elect; and Roy H. Turley, administrator, Espanola Hospital, vice president of the association.

Albuquerque Plays Host to New Mexico Association

• New Mexico hospitals will be reimbursed for the full cost of treatment of welfare patients, under a new state law, instead of $10.50 a day for each patient.

The new law was one of the principal topics at the annual convention of the New Mexico Hospital Association held in Albuquerque recently. Outgoing president Elmer Zaudke, administrator, Atchinson, Topeka and Sante Fe Hospital, Albuquerque, called the law "the greatest thing to happen to the state hospitals in the last 10 years."

Because of Gov. John Simms' efforts on behalf of the law, the association gave him its award of merit as the "outstanding citizen who has done the most to raise the health standards of the people of New Mexico during the past year."

Other highlights of the meeting:

• Approval of a press relations code for the association.

• Announcement that the University of New Mexico will open a school of nursing in the fall of 1955, with approximately 35 beginning students.

Following is HOSPITAL TOPICS report on one of the papers presented at the meeting.

Informed Auxiliary Can Render Invaluable Services to Hospital

Mrs. Josie M. Roberts, Former Administrator, Methodist Hospital, Houston, Tex.—The auxiliary must be informed in order to best serve the hospital. It is the administrator's duty to educate auxiliary members. In some hospitals the auxiliary president is an ex-officio member of the board of trustees. The auxiliary should have contact with the board to have an opportunity to tell what its members are doing to help the hospital.

Auxiliary members can play a vital role in informing the public about proposed legislation affecting hospitals, and in getting people out to the polls.

Most auxiliaries now have a service corps composed of women who can give time to work in the hospital. At the Methodist Hospital in Houston, service corps members work in the admitting office, book cart, blood bank and laboratory, chapel, outpatient clinic, coffee bar, information desk, patient floors, and surgery, and operate the gift shop.

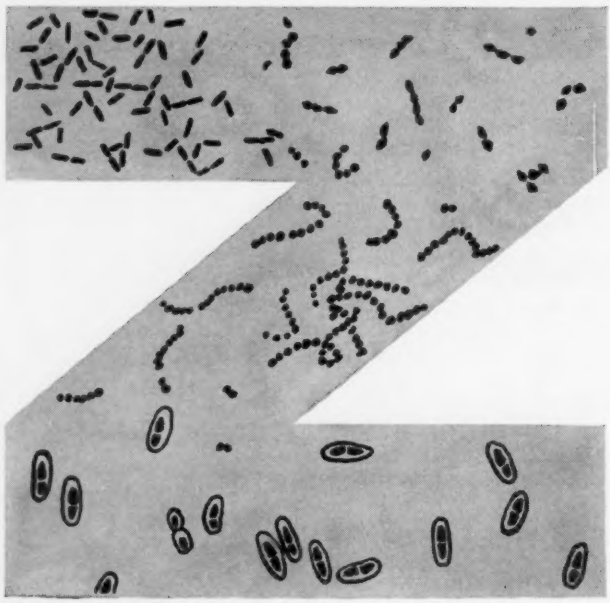
A volunteer must feel needed. Her duties must be outlined so that not only will she know what she is supposed to do, but also the paid employees will know what her duties are.

Employees and volunteers should be selected with great care and be trained in how to meet the public, in person and over the telephone.

A well-organized volunteer service will not only save thousands of dollars for the hospital in salaries, but will make patients happier and more comfortable.

Below: Governor John Simms (l.), is presented with the Award of Merit of the New Mexico Hospital Association by Elmer E. Zaudke, immediate past president and administrator, A.T. & S.F. Hospital, Albuquerque.

AS VERSATILE AS THE ALPHABET



it's dependable

antisepsis

with quick acting economical

Zephiran®
CHLORIDE

high germicidal potency • low toxicity • nonirritating

WINTHROP *Winthrop-Stearns* INC. New York 18, N.Y. • Windsor, Ont.

Zephiran brand of benzalkonium chloride (refined)

Infant Feeding and Emotional Security

By O. William Anderson, M.D.
Seattle, Washington

OB DEPARTMENT

• *The following article is reprinted by permission of the author and* Northwest Medicine, *where it appeared, February, 1955.*

INFANT FEEDING, as with all other technics of our culture, has gone and probably will continue to go through various vogues and fashions. This is true from the nutritional standpoint, but the philosophy of how and when to feed a baby has varied as well. Of course, no one method has at any time been universally used, but it would be fair to say that at various times one approach has been the most popular, or let us say, most talked about.

During the second, third and fourth decades of this century when nutrition as a science was making great strides, infant feeding, especially for the artificially fed infant, was a fertile field for application of many new principles, and it is certain that the baby's lot became a better one, at least from the life-expectancy standpoint. More and more people sought physician help to advise them in care of their babies. Since this new science had learned the fluid, caloric and other nutritional requirements of the baby, the physician adviser set out to use it in such a way that the baby was fed quite exactly the fulfillment of these requirements. This necessitated the preparation of quite an exact formula and the giving of exact amounts of this formula, and it follows that this latter requirement would be better carried out with quite an exact feeding-time schedule.

From a philosophic standpoint it was felt that the baby might as well know at an early age who was boss, and if he were fed in an orderly way, he would be helped to learn at an early age to live an orderly life. As a result, mothers who were breast feeding their babies were encouraged to nurse their babies for given lengths of time and on schedule—this in contrast to former days when most mothers probably fed their babies on semi-schedule worked out by mutual agreement between the mother and child. In retrospect this might be called the era of "exact infant feeding." It goes without saying that in carrying out this regimen in the home a good deal of fudging went on and, on the whole, everything worked out satisfactorily. There were cases where such a plan of exactness was entirely suitable to the mother and child and here again the result was satisfaction. However, there certainly were also cases where these methods were not appropriate, and the conscientious mother blindly attempted to force herself and her baby to do as they were told. The result was frustration for both mother and infant.

RIGID VIEWS RELAXED

It was probably during the thirties that it became apparent that nutrition was not such an exact science and that man had been endowed with a goodly amount of tolerance from the standpoint of his dietary requirements. At least it became apparent that most infants did equally well on several different types of feedings. It seemed to some that probably the only really big advance in the science of infant feeding, other than the knowledge of vitamins, was importance of cleanliness with the milk. As a consequence the formula feeding tended to become less complicated and it seems natural that now the rigidity of amounts to be fed and the time schedule would relax.

The relaxation of rigidity in amounts and timing that could be expected has come about in a big way in the past decade. This has brought in the era of what is called "self-demand infant feeding." It cannot be doubted that this attitude now is a very popular one. For the most part if an infant is artificially fed he now gets a very simple formula. In many cases simple cow's milk that has been properly cared for by pasteurization, curd modification, and so forth, is found satisfactory. Along with this simple feeding the mother is told to feed the child the amount he wants when he is hungry. From the nutritional standpoint the results appear equally as good as those of the "exact" era.

INFANTS, INDIVIDUALITY, EMOTIONS

Again from the philosophic standpoint this era of self-demand feeding has coincided with a period when more and more people have taken a sympathetic attitude toward the emotional well-being and development of the infant from birth on. When the infant is viewed in this way it becomes apparent that he does have an appetite, he does have hunger pains, and he does derive emotional satisfaction from food as well as fulfillment of his physiologic needs. It will be seen also that his appetite varies from time to time and that his hunger pains do not necessarily coincide to the rhythm of some schedule dictated by a third party, and further it will be observed that an infant is an individual. In all these ways he is pretty much like the adult he is going to be.

People who are psychologically minded are finding more and more evidence that the experiences of infancy and early childhood have a profound effect on the entire personality structure of the future adult. It will be agreed that much of this material is as yet controversial, but certainly not entirely so, which means that our attitudes and methods of infant care are tremendously important. Since feeding is one of the most important if not the most important of events in the infant's life, this subject is worthy of much thought.

(Continued on the next page)

The "self-demand" philosophy of infant feeding implies that effort is being made to give the baby the greatest possible emotional gratification, and since he is getting his food in the amount and at the time he wants it, he is given an opportunity of self expression at the earliest possible age. The attitude that people take on this subject varies widely, but to some it has become almost a fetish, and it may be that in those instances the pendulum has swung too far.

NOT SELF DEMAND BUT SELF REGULATION

The late C. A. Aldrich may be considered as one of the pioneers in advocating breaking away from the strict routines. He felt the danger of going too far, and he deplored the term "self-demand" because of the connotation that we were letting our infants make demands on us, which should not be the case. He felt that a better term would be "self-regulation" in that a reasonable effort was being made to feed the infant according to his needs as an individual.[1]

In practice the doctor finds the mothers' response to this plan of feeding their babies an extremely varied one. With most mothers, when a sensible plan is outlined, they will respond that they agree that it is best to try to work things out best for their baby. There are other mothers, however, who, when feeding is being discussed, reveal a spoken or unspoken need for specific instructions and feel lost and uncertain and afraid to proceed until they have been told specifically what to do. Many of this group, if they are not finally given specific instructions, will proceed to put the baby on a time-and-amount schedule of their own choosing. Usually they are quite unconscious of the fact that they are doing this. Then there is the group who have to do things by extremes, and since they have been told to feed baby when he is hungry, proceed literally to carry out the instruction, sometimes with weird results. (It may be that in these instances they are preparing the infant for a life of anarchy!) A multitude of variations from the mentioned attitudes are seen every day.

BABIES ALSO VARY

As has been said, the authorities' attitude toward this problem varies, and, also, the mothers'. But the babies, themselves, also vary widely. Broadly speaking, there are many infants who seem to make few "demands" and readily adapt to whatever system of care is offered them. Then there are those who very definitely make their needs known. For the most part, this latter group wants to be fed quite often, especially during the first month or two, and it is hard to state any very objective reason why this should not be done. In any case, it would seem that this is the group in which we are interested.

Allowing for the variations in babies that have already been mentioned, the first month is a period when the baby seems to need to eat more frequently and shows no consistent rhythm of timing his "demands." Toward the end of the first month and into the second month, the feedings will usually be less frequent and nearly always a rhythm will begin to reveal itself if the baby has truly been permitted to self-regulate the schedule. It is interesting to note, when this rhythm is developing, that there is a period of twelve to eighteen hours during the day when the baby is eating often and making intense demands—then the remainder of the twenty-four-hour day is more or less quiet, as if he had done a day's work of living and growing and is now off for his night's sleep. This is fine when his night's sleep comes at night, and it is an interesting phenomenon that the vast majority of babies "work" during the day and sleep at night, showing an instinctive recognition of the day's division. Certain it is that there are those who seem to lack this instinct and their parents are to be pitied. With this latter group, trying to get them changed around to our way of living can be a very great chore.

There are a few babies, and they seem to be relatively small in number, who do not show this tendency to settle down to a rhythm, and if the mother is carrying out the self-regulation scheme, she may go some months still unable to plan any pattern for her day, as she never knows in advance when she will need to be caring for her baby.

From the mother's standpoint, the self-regulation plan of feeding can be a handicap, as she has other things to do than care for the baby, and probably should have. Most mothers willingly accept the necessity of devoting their entire time during the first month to infant care but thereafter feel an increasing need to get on with other activities. No matter how conscientious a mother may be in the care of her infant, if he confines her too completely too long, an unconscious resentment will be built up that is neither to the advantage of the child or the mother.

INSECURITY IS NOT PREDICTABLE

In recent years with the increased interest there has been in the infant's emotionality, there has been a realization of an infant's need for emotional security and the many ways in which he derives this sense of security. This need for security is more obvious and much greater in some infants than in others, especially from six months on. Some observers can see these manifestations much earlier —even to the new-born period. This latter area is controversial and need not be discussed here because it seems fair to say that what has gone on during the first six months will already have influenced the baby. Although not all babies will show a tendency to easy insecurity at a later date, we have no way of anticipating those who will; it would therefore seem best to treat them all in the manner least likely to worry the baby. Also, when we realize how well concealed a severe feeling of insecurity can be in adults, wouldn't it be safe to assume some similar concealment in the young adult—that is, the young infant?

An infant derives a sense of security in many ways. One very important way is through stability of his environment and routine. In other words, the infant feels safest if each day he is in the same house with the same people doing the same things. The activities going on in the house that are of most concern to him are those involving his personal care; and since, as we have said before, eating is probably his most important and gratifying activity, would it not follow that a definite routine for his feeding would enhance his sense of security?

SOME NEED LIMITS

Another concept in human behavior that has been brought to the fore in recent years by the science of psychiatry is that the human psyche needs as limitations the bounds put around it by society. Man with his ego is quite ambivalent about this matter, often asserting that he needs no restrictions, yet the psychiatrists tell us that much seemingly unsocial behavior, especially in a child, is the unconscious thrashing about asking that limits be set—possibly reflecting man's need for government, his resentment of himself for needing it, and of government for giving him what he needs.

Might not this concept also be applicable to infants? Admittedly some need these limits more than others. It might well be that gently helping the child to accept a

(Continued on the next page)

1. Aldrich, C. A., and Hewitt, E. S., A self-regulation feeding program for infants, J.A.M.A. 135:340, (Oct. 11) 1947.

routine might be his first taste of government, thus minimizing his need to search for limits at a later age. On this hypothesis those infants who go on past the first month of infancy anarchistically making demands without rhythm may already at an early age be groping for a setting of limits and therefore would respond favorably to a gentle goading into some sort of rhythm.

It would seem that a logical middle ground in this matter would be to feed the baby as often as he is hungry for the first month or so, at the end of which time most babies show a rhythm by which they would like to be fed, then in those cases settle down to the baby's routine. Since the days would then be all alike, the mother could plan her day and all should work out well. However, the baby who still in the second month has no sign of a schedule should be gradually forced into one, both for his and the mother's sake.

CONSTITUTIONAL TOLERANCE FOR FOIBLES

Another significant change in infant feeding technic that has been increasingly popular during the past two decades is the feeding of solid foods at much earlier ages than in times past. Previously it was uncommon to even offer foods, other than milk, earlier than six months. Now most babies are given a variety of solid foods such as cereal, fruits and vegetables, as early as three months. And in many, perhaps a goodly majority of instances, some solids are started as early as one month. There are, of course, extremists here as in any other similar situation who make it a practice to feed infants as young as two weeks of age a variety of solid foods. This latter practice seems more like a stunt. The fact that the infant survives such treatment may be taken as testimony to the fact that the average infant has a wider constitutional tolerance for the foibles of his supposed superiors than our ancestors were aware of. This extreme practice is by a small minority and probably always will be, so will not be considered in this discussion.

However, there is little question that the practice of feeding solid foods beginning in the second or third months is here to stay. The question, therefore, of just how to do this best is worthy of thought and discussion. There is much evidence that the over-all health of our infants has improved during the last half century, but since many important developments have occurred during this time, there is no objective way of measuring how much good has been done by the early feeding of solid foods. There are those conservative pediatricians who are unwilling to give any definite credit to this particular change, and would argue instead that the fact that the infant tolerates what we give him is no proof that he needed or profitably utilized what we gave him.

While the profession may argue the pros and cons of this matter dispassionately, the lay public has come to form quite definite opinions, and for the most part the consensus is one of acceptance. In fact, the average young mother of today has come to think of this early feeding of solids as quite essential. For this reason when we find an infant who is not taking solid foods well, a problem of no small magnitude develops which is very frustrating to both the mother and the infant.

This attitude on the part of mothers has been brought about by the campaigning of manufacturers of prepared infant foods as much as it has been by the medical profession. These manufacturers have not only made their products readily available in convenient, reliable and fairly inexpensive forms, but more important for purposes of this discussion, have made an endless variety of products, equally available.

NEED FOR VARIETY NOT ESTABLISHED

As the feeling has become prevalent among mothers that it is essential that they feed solid foods at an early age, likewise they feel that the baby either needs or should have a wide variety. Since a goodly-sized variety is readily available, the offering of variety is no problem. Probably one reason for the mother's efforts to give a variety of foods is that she assumes that the infant enjoys and appreciates a diversity of diets as do adults. It should be mentioned here that while a wide range of foods is admittedly pleasant to an adult, it is not essential for health.

Basically the solid foods that are commonly given the infant are the cereals, fruits and vegetables, and more recently meats have been becoming quite popular. From the nutritional standpoint all of the members of each group have at least similar food values. Again from a nutritional standpoint good growth and health will result if the diet has only a few or perhaps just one member of each group given continuously. The question is, how important is variety from a taste standpoint?

Again with this question, as was true with the question of feeding schedules, the infants are individuals and vary in their reactions to the solid foods fed to them. There are babies who seem to show little interest in what they are fed, just so they are fed—it might be said that they show little taste reaction. But there are those who at a very early age definitely taste their food and show their likes and dislikes. Certain it is that when they pass infancy and learn to express themselves better the majority of children show their likes and dislikes quite obviously and the same majority tend to narrow the diet that they will take willingly or with pleasure. In other words, it might be said that children tend to like a monotonous diet. Isn't it possible that this same satisfaction with monotony in foods that the child is acquainted with might extend back into infancy when he was less well able to express himself? It would seem that if an infant derives security from sameness in his environment and living routine, it would be accepted as a corollary that he obtains similar assurance from sameness of diet.

It is a common experience nowadays to have a mother complain anxiously that her infant will only take two vegetables and spit out all of the rest of them. This type of story is heard with endless variations. At times, one senses in the mother a concern for her baby's health if he doesn't get a wider variety—at other times one feels that the mother is frustrated by the infant's lack of appreciation for her efforts to make his diet interesting. In either case, it seems unfortunate that this conflict should take place if it is admitted that the diversity of foods is not necessary.

When Your Instruments Get Sick
CONTACT US FOR QUICK SERVICE
- Resharpening
- Polishing
- Tables and chairs reconditioned
- Mercury cleaned . . . chemically pure
- Mailing facilities for out of town
- Pick up and delivery St. Louis and vicinity
- Guaranteed to your satisfaction

Medical Instrument Repair Company
524 TWEED DRIVE • LEMAY 23, MO.
TWinbrook 2-2347 • WOodland 1-0503

THIS IS THE BIG ARMSTRONG DE LUXE H-H BABY INCUBATOR

1—4 easy-opening, easy-closing, double-sealed, non-mechanical Hand Holes.

2—A BIG Incubator, big enough for a baby 25" (63 cm) long.

3—Self-purging Nebulizer for either water or other medication such as Alevaire.

4—New solid stainless steel Atomizer now in the Nebulizer. Simple, 2-piece, easy to clean.

5—Supersaturated atmospheres either with or without oxygen.

6—Either LOW or HIGH oxygen concentrations—as you wish.

7—Price includes 4-compartment, easy-rolling, cabinet base.

8—Bottom tray and interior trim of Incubator Stainless steel for easy cleaning.

9—Underwriters' Laboratories and Canadian Standards Association tested and approved.

10—NO motor, NO fan to clean or service.

11—NO forced draft ventilation. Air, oxygen or fog all move naturally and safely thru the Incubator. Should the power fail the air still moves.

12—Heating unit guaranteed service-free for 3 years.

13—Automatic Fenwall Thermoswitch control.

14—Slide opening in the end for parenteral fluids, etc.

15—All 4 sides heavy ¼" clear shining Plexiglas with ¼" safety glass top all set in a rigid steel frame for strength and complete visibility.

16—Tilting bed, foam mattress, vinyl plastic covers, extra hand-hole sleeves, 2 white duck weighing hammocks, metal armored F & C thermometer, directional flow control Oxygen inlet and many other details ALL included in the one LOW PRICE. (Only the Scales, when needed, are extra).

WRITE FOR COMPLETE DETAILS AND PRICES

"AND IT DOESN'T COST A FORTUNE," *he said*

Talking with a physician at a recent meeting, he told us why he liked the new Armstrong De Luxe H-H Baby Incubator—and then, just as he was leaving, he remarked, "and it doesn't cost a fortune, either."

THE GORDON ARMSTRONG COMPANY, INC.

504 Bulkley Building, Cleveland 15, Ohio

Distributed in Canada by Ingram & Bell, Ltd.

TORONTO • MONTREAL • WINNIPEG • CALGARY • VANCOUVER

Caring for Pediatric Polio Cases

Pediatric Nursing

● The success of the Salk poliomyelitis vaccine means that the end of polio epidemics and the disease itself is in sight. Meanwhile, should hospitals unequipped to handle contagious diseases accept polio cases? At Michael Reese Hospital, Chicago, the answer to that question is yes, thanks to a successful polio-care program started some years ago. Although the program is designed to meet specific needs at Michael Reese, many of its procedures are adaptable to other hospitals.

Below: Student nurse in Sarah Morris, the children's division of Michael Reese Hospital, is shown feeding a polio patient in juvenile respirator. In-service training course teaches respirator nursing care to students, practical nurses, aides, etc.

Key factor in the success of the Michael Reese Hospital program is a special Poliomyelitis Advisory Committee which meets in April or May of each year to plan ahead for the summer polio season. It is composed of representatives from each department in the hospital concerned with polio treatment, including pediatrics, neurology, anesthesia, physical medicine, nursing, orthopedics, social service and administration. Members discuss the previous years polio experiences, report on the availability of new and old equipment and supplies, decide how best to integrate the services of various departments, and generally approve policies to be followed.

One of the first decisions made concerns the number of polio patients the hospital will accept. Betty Baumbach, R.N., Administrative Supervisor of Sarah Morris Hospital, the children's division of Michael Reese, sets up her nursing unit with this figure in mind. Later, if circumstances warrant accepting more patients, the committee meets again and plans are revised.

Polio patients are not kept in separate isolation wards at Michael Reese under ordinary circumstances. In 1952, a record polio epidemic year in Chicago, the polio committee did set aside one entire floor in Sarah Morris Hospital for both adult and pediatric cases. This emergency measure necessitated the movement of a great deal of equipment from other parts of the hospital and temporarily drew off some nursing personnel. The usual procedure followed at Sarah Morris is as follows:

One division, as centrally located as possible, is selected to receive pediatric polio cases, and certain rooms in this division—four and two-bed rooms and single-bed rooms—are set aside for polio use. One is set up as an operating room and kept in readiness for emergency tracheotomies; some of the supplies to be used are also stored in this room.

Mrs. Baumbach chooses one or two rooms to receive the first patients. Bed boards are placed under the mattresses of the bed for the protection of the patient's spines and foot boards are installed to avoid possible foot drop. Later, as these rooms are filled, others are prepared.

Isolation technic is similar to that followed in treating other contagious diseases. All rooms in the children's division have screen doors and these are kept tightly shut

(Continued on next page)

Above: Betty Baumbach, R.N., Administrative Supervisor, Sarah Morris Hospital, stands behind the Bennett Intermittent Positive Pressure Breathing Machine, one of the heavier pieces of polio equipment. Hospital also has two rocking beds, two portable chest respirators, and infant respirator.

during the first stage of the disease. Visitors must stay outside in the hall. Nurses, physicians, physical therapists, aides, etc., who do enter wear gowns and take the usual precautions. Masks are no longer used. Current medical theory suggests that they accumulate infective materials when worn. If a mask is allowed to brush against a contaminated gown or surface for example, it can become a dangerous disease carrier.

Once a polio patient has passed the contagious stage of the disease he is moved to a convalescent unit. The room he has vacated stays empty for 24 hours and is then washed, thoroughly cleaned, and made ready for the next occupant.

Like most other hospitals, Michael Reese has had difficulty in securing adequate nursing personnel to care for polio patients. Many nurses, particularly those with small children of their own, have been afraid of contagion; the new polio vaccine should help dispel this fear. Catherine E. Sheckler, Associate Director of Nursing Service at Michael Reese, believes that fear of catching polio has been diminishing, anyway. She points out that a nurse working in a polio ward where every precaution against contagion is taken, is probably safer than an individual out on the street, riding crowded streetcars, shopping in department stores, etc.

The number of registered nurses needed for polio care varies, of course, with the number of cases to be treated, the illness of the patient and the availability of other nursing help. Both Miss Sheckler and Mrs. Baumbach believe the services of practical nurses are vitally important. A good practical nurse can watch for changes of color in tracheotomy cases, care for respirator patients and, if necessary, help the personnel from physical medicine apply hot packs. Attendants can be trained to do some of this work, also. Bulbar patients and those with spinal paralysis require the almost-constant services of an R. N.

What preliminary training is necessary? At Michael Reese an in-service training institute is held each spring for graduate nurses, students and auxiliary personnel. A 12 to 14 hour course on polio theory, equipment and treatment, it serves mostly as a refresher course because the majority of today's nurses have worked in polio wards. Last year's program, which is fairly typical, covered the following subjects:

1. Medical Aspects of Poliomyelitis
2. Responsibilities of the Physical therapist and Physical therapy department in the care of the patient with poliomyelitis
3. Nursing care of a patient with polio upon admission and during the acute stage
4. Nursing care of a patient with bulbar type of poliomyelitis
5. Nursing care of patients requiring mechanical aids for respiration

Equipment at Michael Reese includes seven respirators, two portable chest respirators, two rocking beds and a Bennett Intermittent Positive Pressure breathing machine (shown on this page), five tracheotomy trays, bronchoscopy trays and a variety of other smaller items. The average hospital, of course, does not have access to this much equipment; minimum requirements would vary according to a hospital's size and location.

Last year Michael Reese treated 109 polio patients. Careful planning and good teamwork on the part of everyone connected with the polio-care program made it possible for the hospital to accept and adequately care for these people.

Below: F. Sagguilig, R.N., stands in front of screen door at the entrance to a room in the children's division. These doors are kept tightly shut during acute polio phase; visitors talk through the screen to patients inside.

ROUTE TO

O. R. SUPERVISOR.....

SURGICAL WARDS.....

OB-GYN .....

MEDICAL WARDS.....

O. P. D.....

PHARMACIST .....

EMERGENCY .....

REMARKS:

Every member of your staff using a skin antiseptic will benefit from

Bactine®

BRAND

nonirritating, nondrying germicide • protects for hours • fresh, clean odor

superior for

- pre-surgical hand prep
- pre-operative skin prep
- preparation of injection sites
- first aid—cleansing contaminated wounds
- soothing back rub

BACTINE: Available in 1-gallon, 1-pint and 6-ounce bottles.

Save money and shelf space with CONCENTRATED *Bactine*—a pint makes a gallon of standard BACTINE. For professional use.

Write to Dept. FE for trial supply and professional brochure.

MILES LABORATORIES, INC • ELKHART, INDIANA

09958

BUYER'S GUIDE

For your convenience in requesting full information on these new products, each news flash is numbered. By circling the corresponding number on the postage-paid card opposite this page you will receive complete information at once.

501. Room divider screen

Provides privacy in two-bed rooms, eliminating need for expensive all-around cubicle curtains, old-fashioned accordion screens. Nurse just flips six foot boom up into position and whisks curtain across. Drop the boom and the whole assembly lies flat against the wall out of the way. Corrosion-proof anodized aluminum with steel curtain rings, stainless steel halyard that supports many pounds. Six feet long, five feet high curtain is white, non-transparent, washable, sanforized jean cloth. Polecats, Inc.

502. Neoprene foam mattress

Neoprene, synthetic rubber produced by Du Pont, does not support combustion. Made into foam mattresses, its comfort, durability and safety has been established by the U. S. Navy in extensive trials under actual service conditions. Tried also on hospital ships, these mattresses proved easier to clean and sterilize. Withstands steam sterilizing. E. I. Du Pont De Nemours & Company.

503. Syringe cleaner

Portable syringe cleaner of stainless steel has five removable circular racks and partitions to accommodate matched pairs of barrels and plungers. Capacity is up to 156 syringes. Jet spray is directed to each individual piece. There are two simple controls to adjust; signal light is on while machine is operating. American Sterilizer Company.

504. Synthetic laundry rinse

Sta-Puf is a new rinse developed to make clothes softer, fluffier and easier to iron. Not a soap, detergent, starch or water softener, it is said to make diapers soft and easier to pin, give textile fibers resiliency and softness even when hardened and coarsened by numerous washings. Below, F. W. Apperson, sales manager, A. E. Staley Co., explains the special properties of Sta-Puf to Mary Alice Cook, laundry specialist, Hot Point, Chicago, at luncheon at which the new product was introduced. A. E. Staley Manufacturing Company.

505. Plastic catheter bag

Clayton vinyl plastic bag provides easier use of catheter for ambulatory patients. Attaches to the leg below the knee and to the catheter with plastic connector. Tiny gap in the top of the bag running along the length of the tube serves as air vent. Centrally located tape results in self-righting action, prevents spillage whether patient is walking or sitting. The Bittner Corporation.

506. Disposable surgery cape

Made of soft, fabric-like material, cape is opaque, pleasant to the touch and comfortable to wear. One size fits all adults and it is fastened with a tie string around the waist. Use of low cost disposable cape saves laundering and replacement of cloth gowns and sheets. Central State Paper and Bag Co.

BUYER'S GUIDE Information Service

501. Screen for dividing rooms
502. Synthetic rubber mattress
503. Portable syringe cleaner
504. Synthetic laundry rinse
505. Vinyl catheter bag
506. Disposable surgery cape
507. Adjustable operating light
508. For radiation measurement
509. Holds bottle as mom would
510. Room deodorizer in bulb form
511. Eye magnet is explosion-proof
512. Plastic coated coffee cups
513. Metal foil suture packages
514. It washes lab equipment
515. Handy emergency lights
516. A contour vibrator pillow
517. It re-threads broom handles
518. Prevents glass breakage
519. A blood donor set
520. Glascote, the liquid tile
521. A non-porous fiberglass tray
522. Prescription containers
523. Individual saccharin packets
524. A heavy-duty bulletin board
525. Combination blood pump
526. Acid and alkali burns solution
527. Nurse uniform catalog
528. Beem bed brochure
529. Clark vein stripper
530. Safety check blanket
531. Institutions directory
532. Infant incubator
533. Booklet for administrators
534. Multi-Clean line
535. Food cost control
536. Air conditioning guide
537. A.O.R.N. pins and rings
550. Positive identification
551. Illotycin antibiotic
552. Disposable plastic blood pack
553. Audio-visual call system
554. Floor waxes and cleaners
555. Standard stretcher
556. Tillary retractors
557. Radiant heat sterilizer
558. Non-specific disinfectant
559. Biological research enclosure

USE THIS CARD

If you would like additional information on the items listed in the Buyer's Guide section, just circle the number on the postpaid reply card for information you desire. For your convenience, we have placed a reference guide listing on this page referring to the product that goes with the number.

Postage Will be Paid by Addressee

No Postage Stamp Necessary If Mailed in the United States

BUSINESS REPLY CARD
First Class Permit No. 34341, Sec. 34.9, P. L. & R., Chicago, Illinois

HOSPITAL TOPICS
30 West Washington Street
Chicago 2, Ill.

Send more information on items circled. MAY, 1955

501.	508.	515.	522.	529.	536.	555.
502.	509.	516.	523.	530.	537.	556.
503.	510.	517.	524.	531.	550.	557.
504.	511.	518.	525.	532.	551.	558.
505.	512.	519.	526.	533.	552.	559.
506.	513.	520.	527.	534.	553.	
507.	514.	521.	528.	535.	554.	

Other information .....

Name .....Position .....
(Please Print)

Hospital .....

Address .....

City .....Zone .....State .....

BUYER'S GUIDE Information Service

USE THIS CARD

If you would like additional information on the items listed in the Buyer's Guide section, just circle the number on the postpaid reply card for information you desire. For your convenience, we have placed a reference guide listing on this page referring to the product that goes with the number.

501. Screen for dividing rooms
502. Synthetic rubber mattress
503. Portable syringe cleaner
504. Synthetic laundry rinse
505. Vinyl catheter bag
506. Disposable surgery cape
507. Adjustable operating light
508. For radiation measurement
509. Holds bottle as mom would
510. Room deodorizer in bulb form
511. Eye magnet is explosion-proof
512. Plastic-coated coffee cups
513. Metal foil suture packages
514. It washes lab equipment
515. Handy emergency lights
516. A contour vibrator pillow
517. It re-threads broom handles
518. Prevents glass breakage
519. A blood donor set
520. Glascote, the liquid tile
521. A non-porous fiberglass tray
522. Prescription containers
523. Individual saccharin packets
524. A heavy-duty bulletin board
525. Combination blood pump
526. Acid and alkali burns solution
527. Nurse uniform catalog
528. Beem bed brochure
529. Clark vein stripper
530. Safety check blanket
531. Institutions directory
532. Infant incubator
533. Booklet for administrators
534. Multi-Clean line
535. Food cost control
536. Air conditioning guide
537. A.O.R.N. pins and rings
550. Positive identification
551. Illotycin antibiotic
552. Disposable plastic blood pack
553. Audio-visual call system
554. Floor waxes and cleaners
555. Standard stretcher
556. Tillary retractors
557. Radiant heat sterilizer
558. Non-specific disinfectant
559. Biological research enclosure

Send more information on items circled. **MAY, 1955**

501.	508.	515.	522.	529.	536.	555.
502.	509.	516.	523.	530.	537.	556.
503.	510.	517.	524.	531.	550.	557.
504.	511.	518.	525.	532.	551.	558.
505.	512.	519.	526.	533.	552.	559.
506.	513.	520.	527.	534.	553.	
507.	514.	521.	528.	535.	554.	

Other information .....

Name .....Position .....
(Please Print)

Hospital .....

Address .....

City .....Zone .....State .....

Postage Will be Paid by Addressee

No Postage Stamp Necessary If Mailed in the United States

BUSINESS REPLY CARD
First Class Permit No. 34341, Sec. 34.9, P. L. & R., Chicago, Illinois

HOSPITAL TOPICS
30 West Washington Street
Chicago 2, Ill.

for positive

identification

Gudebrod

COLOR CODED

TRADE MARK PAT. APPLIED FOR

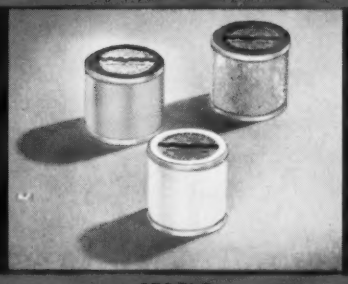
SUTURES

4-0 PINK 3-0 BLUE 00 WHITE

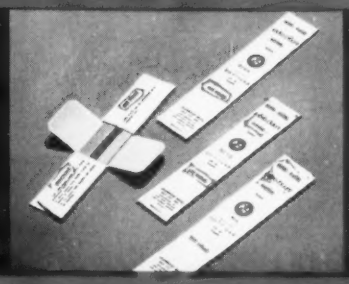
Correct size suture is immediately selected when the ORN supplies Gudebrod COLOR CODED—no hesitation, never a question.

An exclusive GUDEBROD feature SURE AS A FINGERPRINT

Available in CHAMPION serum-proof silk or HAND-CRAFT cotton



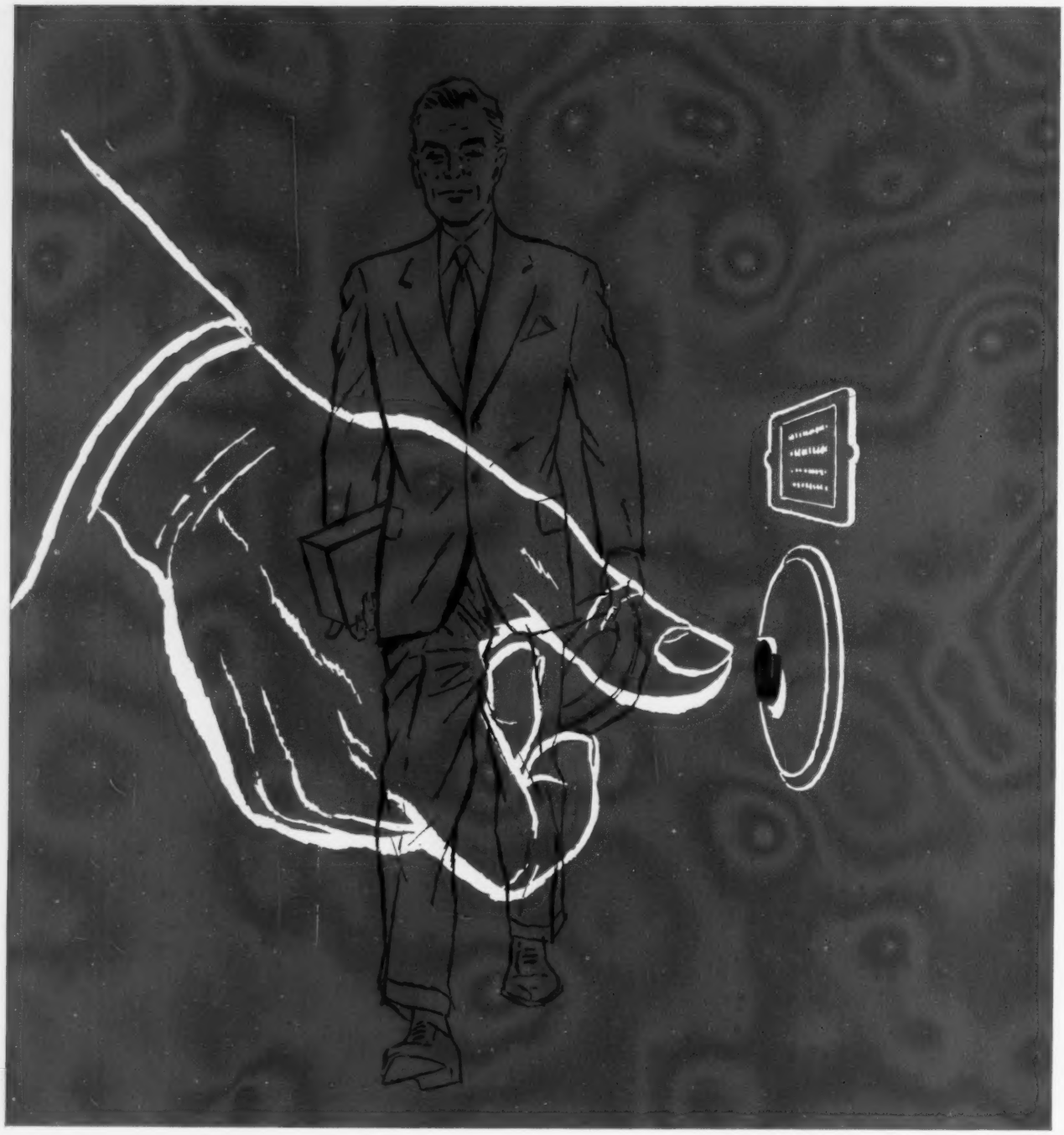
SPOOLS



GUDE-PACK

DRI-PAK®

®T.M.



The man behind the thumb

He visits you regularly and he's quickly within reach by telephone. He supplies you with surgical dressings, instruments, rubber goods, equipment—keeps your inventories level and fresh. He's "on the button," too, when emergencies strike. Responsibility, dependability, consideration are his watchwords. He's your Surgical Supply Dealer, the sole distributor of surgical products manufactured by The Seamless Rubber Company. This tribute to him is presented out of respect for the faithful, efficient services he gives you.

507. Adjustable operating light

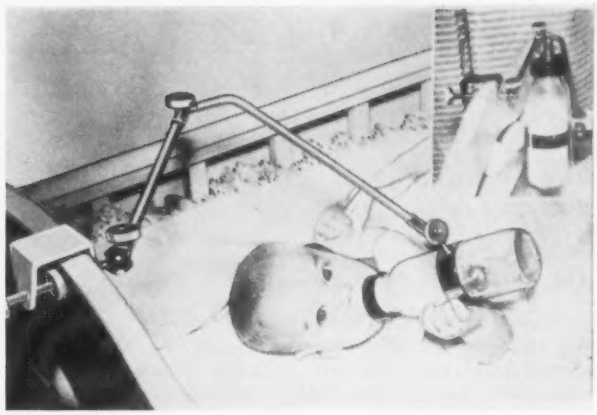
Operating surgeons can adjust this light themselves without changing position or interrupting surgical procedure. Provides illumination from any overhead or extreme side position without moving patient or table. Center pilot spotlight gives extra penetration, can be hooked to emergency circuit or have lighting element removed to house adaptors for foot-pedal actuated still or motion picture camera. Three models. Wilmot Castle Company.

508. Radiation meter with detector probes

Probitron offers a new system for the measurement of radiation rates. One feature of special interest to radiologists and medical investigators is a series of small-diameter probes that can be used for dose rate measurements in small cavities and at other points inaccessible to gas-filled chambers of equivalent sensitivity. Ideal for plotting high-resolution isodose contours in phantoms. Set includes control unit, probe, large-crystal detector and set of accessories for the routine tracer tests used in medical diagnosis. R-C Scientific Instrument Company.

509. Safe-T-Tilt bottle holder

Holds baby bottle just as nurse or mother would; will not slip, adjusts easily to any position. Bottle fits into spring-clip, plastic-coated holder of lightweight anodized aluminum, secured to crib by turn of a knob. Easily cleaned



and sterilized. Designed to save time for busy hospital aides and nurses. The Bava Company.

510. Electronic room deodorizer

Removes medicinal and other odors by means of Westinghouse Odorout bulbs concealed in special night light cases. Bulbs produce ozone that destroys odor-carrying carbon particles in the air. Two models—one pictured above for children's wards; the other, a special vitrified china case carrying the medical caduceus on the front. Kissner Industries, Inc.

DISPOSABLE **PLASTIC** MICROSCOPE **COVERSLIPS**

Robert Busse Patent

for Urology
Parasitology
Blood Smears, Etc.

1/4 The Price of Glass

- Won't Cut Fingers
- Unbreakable
- Lie Flat

	Price per M, 22MM or smaller (100 to box)	Larger sizes to 24x60 (1000 to box)
10M	$3.50	$5.00
2M to 9M	$5.00	$7.00
Less than 2M	$7.00	$9.00

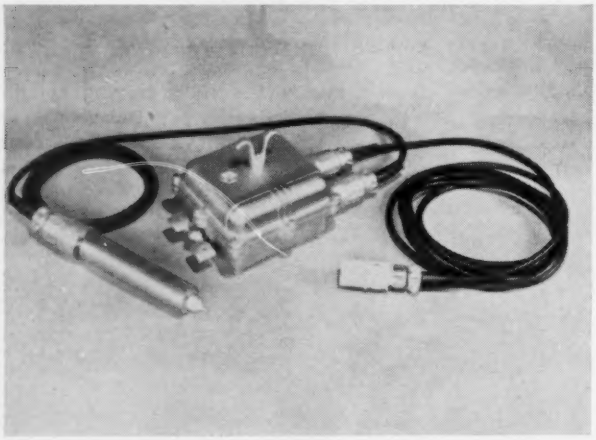
ROBERT BUSSE & CO., Inc.
64 EAST 8th ST. N. Y. 3 GR. 5-8783

BUYER'S GUIDE

Continued

511. Explosion-proof eye magnet

Designed to remove metal particles from human eyes, electrically operated eye magnet housed in explosion-proof enclosures protects hospital operating room personnel and patients from the hazards of highly inflammable anesthetics as propylene, ether, cyclopropane and ethylene. Unit consists of cylindrical electro-magnet with silver-plated tip, rectifier, foot-operated switch, and a 110 volt outlet plug. Crouse-Hinds Company.



512. Plastic-coated paper coffee cups

Plastic-Cup coffee containers are taste-free, designed to withstand heat without separating coating from the carton. For use at lunch counters, meal trays, etc., they have fold-back paper handles, stack easily. Sealright Company.

513. Metal foil package for sutures

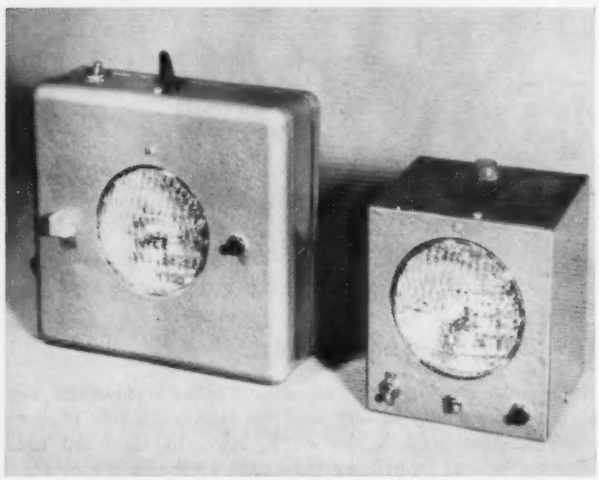
Sterile, metal foil suture package is designed to eliminate the need for glass suture tubes, solutions and jars in the operating room. Surgilope is a double envelope. The outside envelope is sealed metal foil which protects a glassine envelope containing 17 strands of Anacap sutures each 18" long. The circulating nurse can open the foil envelope in the operating room and remove the inner envelope with sterile forceps. This enables the scrub nurse to remove the sterile sutures quickly and easily. Samples are available to hospitals upon request. Davis & Geck, Inc.

514. Detergent for laboratory equipment

Alcowet, specifically designed for washing laboratory equipment, removes difficult stains, prevents spotting of glassware caused by quick machine drying operations. Alconox, Inc.

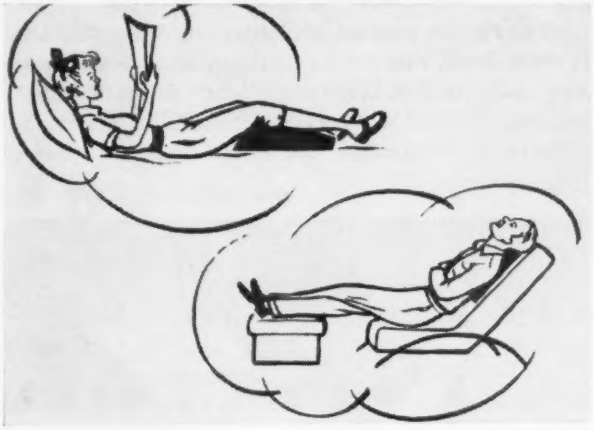
515. Safety lights

Safeguard Lites are designed to automatically supply light by battery power when electricity fails. They turn on as soon as electric current stops, stay on until it is restored. Compact and lightweight, they make handy emergency lights, serve as powerful searchlights when not plugged into the electrical current. Place in corridors, rooms, any spot where proper light is a safety factor. Five models. Jamil, Inc.



516. All-purpose mechanical pillow

Contour vibrator pillow is designed and contoured to massage any part of the body while patient sits up or reclines. Operates on 110 volts, A.C.; guaranteed for one year. Relax It Vibrator, Inc.



517. Taylor hand lathe

Compact, easy-to-use hand tool, re-threads broken broom handles in less than three minutes. Constructed of durable die-cast metal, it has sharp, long-lasting cutting edges of tool steel. Plas-Ties Company.

518. Protection for glasses

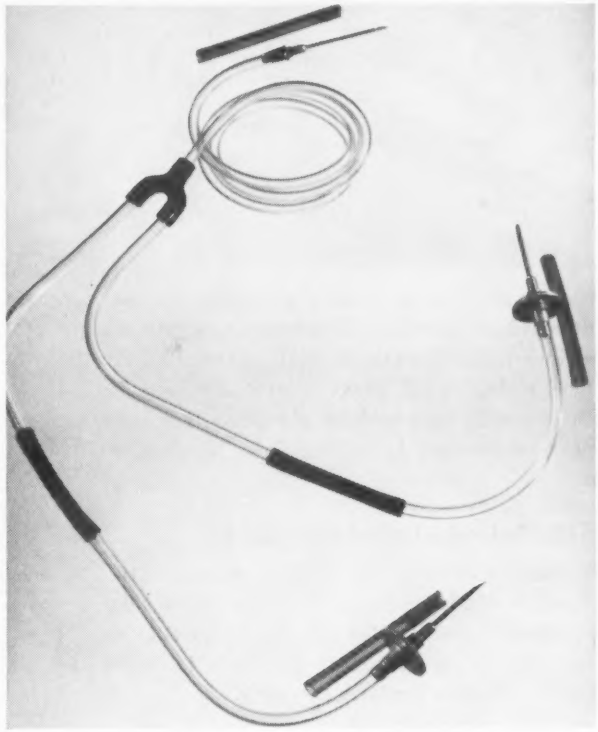
New plastisol-lined compartment Sani-Stack racks help prevent glass breakage. Each glass has its own resilient plastisol-coated compartment which absorbs shock, prevents scratching and eliminates noise. Metropolitan Wire Goods Corporation.

520. Liquid tile

Glascote is applied like paint, bakes into a smooth, hard, waterproof surface. Helps protect walls, floors and concrete tank linings subject to attack by acids, caustics, salt water, alcohol, grease, etc. Comes in quarts or gallons; five colors. Ev-R-Shield Products, Inc.

519. Blood donor set

Saftidonor "Y" set simultaneously draws two 250 cc. half units of blood from one donor; eliminates splitting 500 cc. donations for pediatrics units. Set connects a 17-gauge donor needle and tubing through a "Y" to two lengths of tubing leading to the 15-gauge bottle needles. Safticlamps are built into each "Y" tube for accurate control of blood flow into each 250 cc. flask. Cutter Laboratories.



521. Toteline fiberglass tray

Smooth, non-porous surface of this tray can't rust, chip, absorb odors or peel. Made of fiberglass and polyester resins, rounded corners make it easy to keep clean; hot

water or steam cleans surface quickly and easily. Lighter and stronger than steel on a strength-weight basis; can't warp or rot. Measures 14¼" x 25¼" and is 1⅛" deep. Molded Fiberglass Tray Company.

BUYER'S GUIDE

Continued

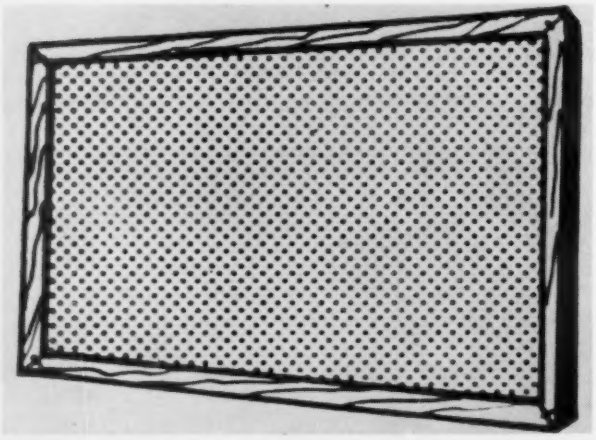
522. Space-saving containers

Shelf ware line of prescription containers are especially designed for hospitals, dispensaries and the modern prescription departments of retail pharmacies. Available in four, eight, 16 and 24-ounce sizes, they are designed for shelf liquids, have medium wide, easy-to-fill mouths, deep pour-out finishes. Armstrong Cork Company.

523. Individual saccharin packets

Sacrinpaks contain two ¼-grain saccharin tablets, each equal to one teaspoonful of sugar, individually wrapped in cellophane. Ideal for placing on hospital meal trays, in cafeteria or restaurant. Available in boxes of 1,000 packets. Pennex Products Company.

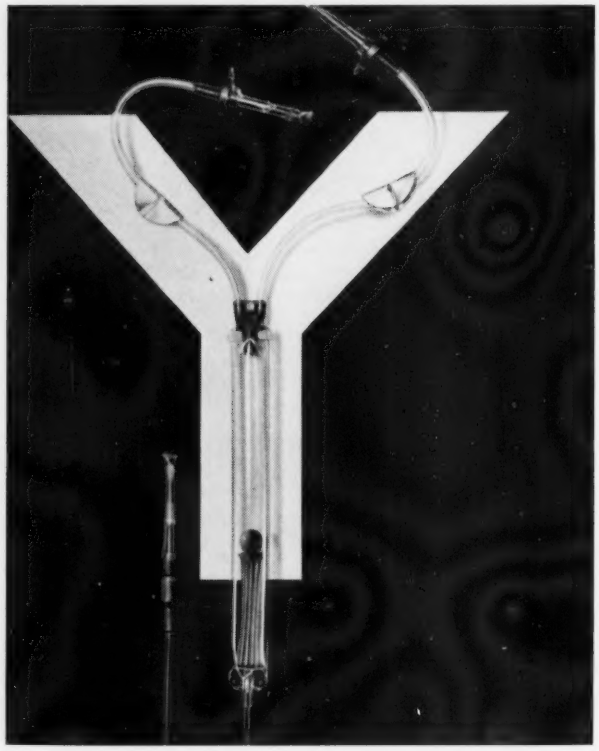
524. Heavy-duty bulletin board



Genuine cork-face bulletin board for all-around use in hospitals and institutions. Fibre board base takes thumb tacks without showing wear. Natural oak frame; metal wall hangers. Available in two sizes—18" x 28", and 24" x 36". General Scientific Equipment Company.

525. Combination Y-set and blood pump

Plexitron R49 simultaneously or alternately administers parenteral solutions and blood; has added advantage of being able to give blood safely under pressure. Pump is located directly below junction of Y, pump housing must be full for pressure administration. When fluid level in pump drops, ball valve also drops, discontinuing pressure administration. This safety feature prevents set from pumping air, enables operator to return to normal administration at any time in a matter of seconds. Baxter Laboratories.



526. Acid and alkali burns solution

A new product, Neutralize, counteracts both acids and alkali burns without inducing new complications, such as might occur when other antidotes are used. Neutralize can be employed safely in high concentrations to assure rapid and penetrating neutralization; simply pour over the eyes or skin to render any chemical neutral. Available in four and 32 ounce polyethylene bottles. E. D. Bullard Company.

FILMS AND NEW LITERATURE

527. Nurses uniform catalog

Dacron uniforms featured in new spring catalog, along with innovations in poplin fabric. Duty dresses sizes seven to 42, tall girl or half sizes. Wrap-around and button-on coachman coat uniforms. White Swan Uniforms.

528. Beem bed brochure

Colorful 12-page booklet, profusely illustrated, on the Beem bed. Shows the new features of head and knee lift, retractable trapeze, self-contained hospital cart, bathroom facilities in the bed, and a self-contained adjustable tray. Beem bed Manufacturing Company.

529. Clark vein stripper

Small folder describes instrument designed to simplify the stripping of varicose veins. Features small and large size fixed ends to accommodate veins of all sizes. Lawton Company.

530. Safety check blanket

Brochure on sanforized canvas blanket. Shows ties that attach to movable frame of hospital bed, strain-resistant center zipper, other special features. Jane Bryant.

531. Institutions directory

New edition features directory of suppliers section with close to 6,000 names and addresses of dealers. Includes new manufacturers' catalogs, classified product listing and a listing of trade names with the manufacturer's name, city and state. Institutions Directory.

532. Infant incubator

Brochure on Isolette, the air conditioned infant incubator with the forced air circulating system. Many colorful pictures with pertinent factors pointed up in picture captions. Air-Shields, Inc.

533. Booklet for administrators

The N.F.P.A. has put out a book called *Hospital Fire Safety.* It includes the contents of booklet number 56 on *Recommended Safe Practice for Hospital Operating Rooms.* National Fire Protection Association.

534. Multi-Clean line

Attractive eight page, two-color pamphlet on *Everything You Need for Better Floor Care.* Presents complete Multi-Clean line which includes: floor and scrubbing machines, industrial vacuum cleaners, rug and upholstery cleaning equipment. Also a liquids chart which describes 24 floor liquids for wood, concrete, etc. Multi-Clean Products, Inc.

535. "Food cost control"

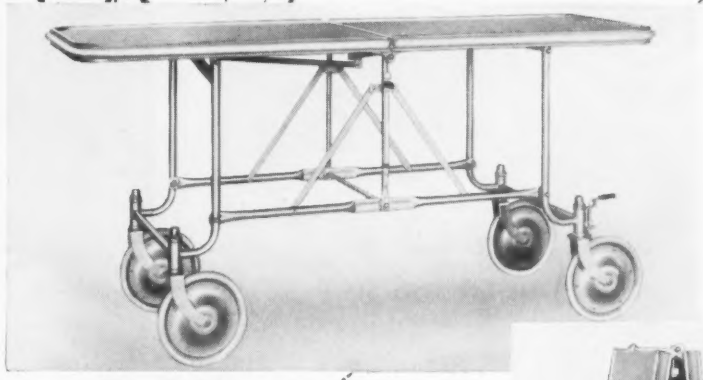
Well illustrated 32-page booklet on fresh-frozen portion—control meats. Introduces Redicut line which includes veal steaks, veal and cheese steaks, cubed beef and onion steaks, breaded chipped beef, Bar-B-Q steaks, and others. Colonial Beef Company.

536. Air conditioning guide

One section of *Guideposts to Better Air Conditioning,* gives tips on ways to apply economical and efficient air conditioning to hospitals and restaurants. Includes a compilation of semi-technical articles by outstanding engineering consultants. E. I. Dupont De Nemours and Company.

537. A.O.R.N. pins and rings

Literature on pins and rings available from Austenal. Brochure tells of lustrous finish that will not corrode or tarnish. Austenal Laboratories.

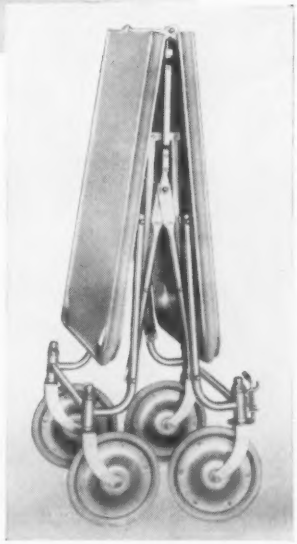


Folding Wheel Stretcher

Store three stretchers where you now store only one!

Folds and unfolds with ease—solves your temporary storage problems—it is the *only* folding wheel stretcher on the market today. The Gendron Model 870 is a full size stretcher, 26" wide—72" long when unfolded for use—but folds into a space saving 21". Equipment consists of a litter of all steel construction, frame of sturdy welded tubing, with litter bumper, 10" ball bearing wheels and rubber tires, swivel fork lock and ball bearing swivel journals, and aluminum bronze, conductive finish.

The Gendron 870 saves you space—*is low cost.* See it at your dealer or write direct to Gendron, Dept. H-55,—for further information.



GENDRON MODEL 870

Gendron Wheel Company

PERRYSBURG, OHIO

Technical Exhibits Thru At The New England

The very latest in hospital equipment and material was displayed in a multitude of booths. These pages highlight some of the products for you.

William W. Howe, representing Franklin C. Hollister, demonstrates the pre-numbered Ident-A-Band made of non-irritating Vinylite to (l. to r.): Ruth S. Mayo, R.N., Mary E. Conway, nursing superintendent, and Barbara E. Mathews, resident in nursing, all of Massachusetts General Hospital, Boston. Bands give positive identification on new baby. Once sealed on wrist, can't come off. Number 550.

D. F. Callahan shows Margaret C. Shea (l.) pharmacist, Norwood (Mass.) Hospital, a package of Illotycin put out by the Eli Lilly Company. It is an effective antibiotic for strep infections. Usual adult dose is one tablet every four to six hours for severe infections. Number 551.

Ralph Cram explains the Fenwal plastic blood pack for the collection, storage, and infusion of blood to Ruby Harris, R.N., Main General Hospital, Portland, Me. It is a completely disposable unit. For added information on this product circle number 552.

Peggy Boon (l.) representing Executone, the audio-visual nurse call system, gives Florence K. Quimby, assistant superintendent, Marion Allison (seated) auxiliary member, and Katherine V. Shea, superintendent, all of North Adams (Mass.) Hospital, added information on the electronic communication system with the instant voice contact feature. Circle number 553 for added information.

Althea Mahoney, (l.) Woburn, Mass., stopped at the Lamco Chemical exhibit where Carl Lamm, company president, explained how Lamco floor wax with carnauba produces maximum gloss, while remaining wear and slip resistant. T. M. Dowd, (r.) secretary to the exhibit manager also listens to Mr. Lamm. For more information about waxes and cleaners circle number 554.

the Eyes of a Camera
Hospital Assembly

• If you are interested in receiving added information on any of the products in this review, just check the number on the post paid reply card opposite page 44. All photos by Hospital Topics.

Helen Leach (l.), tells Elsie Chisholm, nurse anesthetist, Memorial Hospital, Brattleboro, Vt., and Lucille E. La Brecque, anesthetist, Notre Dame Hospital, Bradford, Me., about the Hausted standard stretcher for post-anesthesia and recovery room use. Ray Hausted (r.) company president explains the stretcher can be purchased without accessories and be used for patient transportation. Number 555.

Donald Murison shows Anna Casella, R.N., head nurse, Central Supply, Quincy (Mass.) City Hospital, the Weck tillary retractors. These retractors have a non-glare finish which is good for closed circuit television operations. Added information may be obtained by circling number 556.

G. K. Lermond (l.) representing Wilmot-Castle, shows the new radiant heat sterilizer for sharp instruments to John W. Manz, chief of laundry, and Shirley E. Parkhill, administrative assistant in nursing, both of Grace New Haven (Conn.) Hospital. Circle number 557 for added information.

Felix Bronneck (l.) of Lehn & Fink tells Joan Harrington, R.N., Lemuel Shattuck Infirmary, Boston, about the new improved Lysol. William Kiley (r.) explains the non-toxic qualities of Lysol to Ruth Fielding, R.N., also of Lemuel Shattuck, Boston. For more information on this all-purpose, non-specific disinfectant and antiseptic circle number 558 on the Buyers Guide card.

William Sullivan, M.D., (l.) manager, VA hospital, Providence, R.I., asks Tom Lanahan, representing Blickman, about the stainless steel biological research enclosure for handling bacteria, viruses and radio-isotopes; Abraham Norman (r.) M.D., chief professional services, VA Hospital, Providence, R.I. looks on. For more information on this seamless, crevice-free enclosure, circle number 559.

you can produce
prompt, prolonged
surface anesthesia
with one application of

NUPERCAINAL®

Contains Nupercaine® (dibucaine CIBA), one of the most potent and long-acting anesthetics.

Effective in low concentration —sensitization rare (nonnarcotic —not related to cocaine or procaine).

Useful whenever surface anesthesia is required—burns, surgical dressings, hemorrhoids, abrasions, etc.

Ointment (dibucaine ointment CIBA), 1% Nupercaine in lanolin and petrolatum base.

Cream (dibucaine cream CIBA), 0.5% Nupercaine in water-soluble base.

Ophthalmic Ointment, 0.5% Nupercaine in white petrolatum, applicator-tip tubes.

2/2091M

REVIEW OF HOSPITAL

LAW SUITS

By Leo Parker, Attorney at Law

● *Recently the higher courts in different localities rendered several outstanding decisions involving hospital corporations. Mr. Parker briefly reviewed some of these important lawsuits in an article in the April issue of* **HOSPITAL TOPICS** *(page 53). The article is concluded below.*

RAIN MAKES DANGEROUS CONDITION

A reader asked this question: "Does the law require hospital corporations to use a "high degree" of care in keeping it's premises safe for patients and visitors?"

According to a late higher court decision, the answer is no, only "ordinary" care is required.

For illustration, in Wheeler v. Southeastern, 238 S.W. (2d) 145, it was shown that a woman named Wheeler was wearing high-heeled shoes, was paying no attention to the condition of the floor and her feet slipped from under her in a vestibule on a slick floor. She was severly injured and sued for damages.

Wheeler's counsel argued that the corporation was liable in damages for injuries to Wheeler, because the vestibule was wet from the rain and was dirty from people having walked over it in entering from the sidewalk on a rainy day. The counsel contended that employes of the corporation were negligent in failing to keep the vestibule floor dry and safe.

The higher court refused to agree with these contentions and, in holding the corporation not liable, said:

"There was no negligence in allowing the floor on this vestibule to become slippery from rain and dirt tracked on it by other persons."

INSPECT PREMISES EVERY EIGHT HOURS

Modern higher courts consistently hold that hospital employes are legally obligated to inspect the hospital premises regularly, and eliminate all known dangerous conditions.

For example, in Lehman v. Richfield, 263 Pac. (2d) 13, it was shown that the floors were cleaned at 7:30 A.M. and at 3:30 P.M. a visitor was seriously injured when he slipped on the floor.

The higher courts held that failure of the employes to inspect and clean the floor for eight hours was negligence which resulted in the injured visitor being entitled to recover damages. The higher court said:

"In the case at bar, the evidence showed the premises had not been inspected in eight hours."

For comparison, see Travis v. Metropolitan, 205 Pac. (2d) 475. This court indicated that whether a defective or dangerous condition existed on hospital premises long enough for a reasonably prudent employe to have discovered the peril, is a question for a jury. Also, for further discussion of the law on this subject see Harpke v. Lankershim Estate, 103 Cal. App. (2d) 143; Vaughn v. Montgomery, 213 Pac. (2d) 417, 419; and McKellar v. Penderhast, 156 Pac. (2d) 950.

GIFT OF BONDS UNLAWFUL

According to a late higher court decision, a gift of certain kinds of Government bonds is unlawful, and illegal.

For instance, in Nelson v. Wheeler, 256 Pac. (2d) 1080, the testimony showed fact, as follows: One Alpheus Wheeler had been in and out of a hospital. He carried his belongings in a suitcase and hand bag. He returned to the hospital suffering from a kidney disease. At that time he handed an envelope to a hospital employe and said: "If I don't get well, this is for you." The envelope contained United States savings bonds, series E, all registered in the name of Alpheus. Soon afterwards he died.

In subsequent litigation, the higher court held that the hospital employe could not claim ownership to the bonds, saying:

"Alpheus J. Wheeler, being the registered owner of the bonds, was the legal and equitable owner thereof at all times until the instant of his death. While gifts of other securities and property are recognized as valid in many instances under proper proof under state law, the disposition of United States saving bonds must be administered under federal law. It follows, and we hold, that United States savings bonds, series E, are not subject to gift."

PARKING LOT LIABILITY

A few days ago I received this letter from an official of a hospital, as follows: "I desire to know whether our hospital is required by law to clean snow and ice off our driveway and parking lot which we furnish for use of our patients and visitors. Can an injured visitor who falls on the ice sue us and get damages?"

In Wise v. Great Atlantic, 115 N.E. (2d) 33, it was shown that a parking lot was covered with snow and ice. An automobile owner was seriously injured when she slipped and fell. She sued the parking lot owner for heavy damages, claiming that it was negligent in permitting the ice to accumulate and remain on the parking lot for an unreasonable period of time.

It is interesting to observe that the higher court refused to hold the owner of the parking lot liable, and said:

"In the case at bar, there is no claim that there was any defect in the parking lot or that it was maintained in a dangerous condition, except as to such dangers as were created by the natural accumulation of snow and ice."

For comparison, see Turoff v. Richman, 61 N.E. (2d) 486. In this case the facts are that a parking lot was covered with snow. It had been snowing for a week or more and on the night before the accident about two inches of snow had fallen. The injured person claimed that the owner of the parking lot was liable because he had not cleaned the ice and snow from the parking lot.

The higher court refused to hold that a person who slipped and fell on the parking lot could recover damages.

(Continued on next page)

JURY WILL DECIDE

Considerable discussion has arisen from time to time over the legal question: When a suit is filed against a hospital for injury or death of a patient, who decides whether or not the hospital is liable?

See the late and leading higher court case of Stallman v. Robinson, 260 S. W. (2d) 743. Here four physicians operate a private hospital or sanatorium and are specialists in the care and treatment of the mentally ill. One, Stallman, entered the institution as a patient and four days later committed suicide by hanging or strangling herself with strips of cloth torn from her nightgowns and fastened to a water pipe in the bathroom. Mr. Stallman sued the physicians for heavy damages. The jury awarded $9,000.00 damages, and the physicians appealed to the higher court which affirmed the decision, saying:

"Whether the appellants (physicians) breached their specific duty to reasonably safeguard and protect Mrs. Stallman from injuring herself and committing suicide was for the jury to say."

STATE LAW BARS SUIT

Modern higher courts consistently hold that a law suit is barred if filed after the period prescribed by the State's Statute of Limitation.

For example, in Spears Free Clinic & Hospital v. Maier, 261 Pac. (2d) 489, it was shown that the Spears Free Clinic & Hospital sued a physician named Maier for heavy damages. The hospital charged Maier with libel in signing and recording a death certificate with a statement on the bottom margin that the decedent died from criminal neglect at the hospital; a newspaper publication of a photostatic copy of such certificate was generally circulated. Also, the hospital proved that Maier had stated that the decedent died after having "laid several days, no care" at such hospital.

Since a state law provides that suits of this nature must be filed within a year, the higher court refused to render a decision because the suit was not filed until three years after the alleged libel was committed.

AUTHORITY OF SALESMEN

Recently a hospital official wrote, as follows: "I purchase hospital supplies from salesmen who represent manufacturers, wholesalers and distributors. What I want to know is this: Can I rely on guarantees and contracts made by salesmen?

The answer is: Modern higher courts consistently hold that a salesman's ordinary authority is simply to solicit orders, and send them to his employer for ratification. In other words, ordinarily an employer is not liable for guarantees and contracts made by a salesman. This is so because a salesman is a "special" agent.

On the other hand, it is important to know that where a hospital official places an order with a salesman, who had no authority to make a valid contract of sale, and the employer of the salesman fails to promptly notify the purchaser that the salesman exceeded his authority, the seller is liable on the contract, because by remaining silent and permitting the purchaser to believe that the merchandise ordered would be delivered, the salesman's employer legally "ratifies" the contract of sale.

Ordinarily a "general" agent is one authorized to make valid contracts, guarantees, and promises within the scope of the department that he manages. A "special" agent, as a salesman, has no broad authority. An employer is liable for all acts, within the scope of his business, of a "general" agent, while under the same circumstances he is not responsible for the acts of a "special" agent.

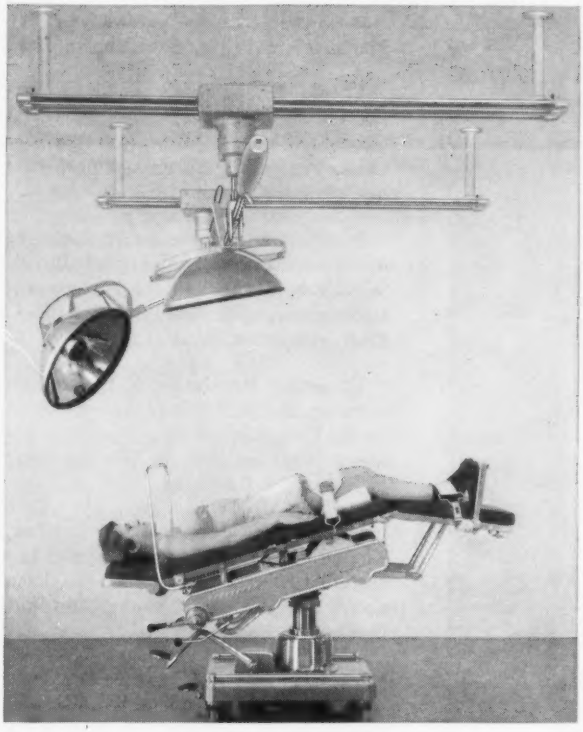
Legally, a "general" agent is an employe who has general authority to act for his employer in the conduction of a business or department of the business. A "special" agent is one who is authorized to act for his employer in one capacity, doing only a single act or several specific acts.

In the recent case of Brager v. Levy, 90 Atl. 102, the court explained the extent of an employer's liability for the acts of a "general" agent, and said:

"A general authority empowers the agent to bind the employer by all the acts within the scope of his employment, and that power cannot be limited by any private order or direction not known to the party dealing with the event . . . It extends further and binds the employer in all cases where the agent is acting within the scope of his usual employment, or is held out to the public, or to the other party, as having competent authority, although in fact he has in the particular instance exceeded or violated his instructions and acted without authority."

Also, see Perry v. Kumberly Company, 23 S. E. (2d) 471. Here it was shown that a sales manager made a contract for his employer. In later litigation the manager testified that he had no authority from his employer to sign the contract, and that in so doing he was acting for himself personally, and not for the employer. However, he admitted that he was the sales manager of this department. Therefore, the higher court held the corporation liable on the contract.

HELP
Guard Against
INFECTIOUS
HEPATITIS
Hasco
SOILED
NEEDLE
CONTAINER
MADE OF STAINLESS STEEL
• Helps Guard Against Infectious Hepatitis.
• Protects Needle Points after use.
• Prevents Needles from Becoming Clogged.
• Efficient Method for Returning Needles to Central Supply.
• Provides Method for Handling Needles During Processing.
Your hospital personnel deserves the same protection against Infectious Hepatitis as your patients.
No. NC25 $9.50 Ea.
Send For Brochure "NA" for Full Details
HAROLD
SUPPLY CORPORATION
100 Fifth Avenue, New York 11, N. Y.
90



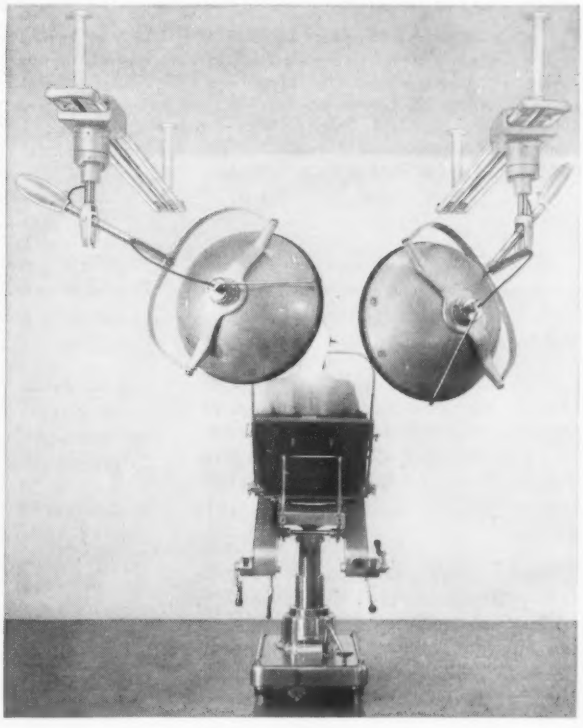
Suprapubic Approach

An INNOVATION in Surgical Lighting

AMERICAN DUAL VIDEO LIGHT

(Cat. No. DV-22C)

As will be seen, no floor lamp is necessary . . . each ceiling-suspended light head delivers intensity of from 1000 to 6000 foot-candles (12,000 in all) as desired by the surgeon.



Neurosurgery

Sterilizable handles are attachable at center of each lightbeam . . . it is now the practical prerogative of the surgeon to position the lightbeam exactly where he wants it. Circulating nurse may also maneuver light by the remote control.

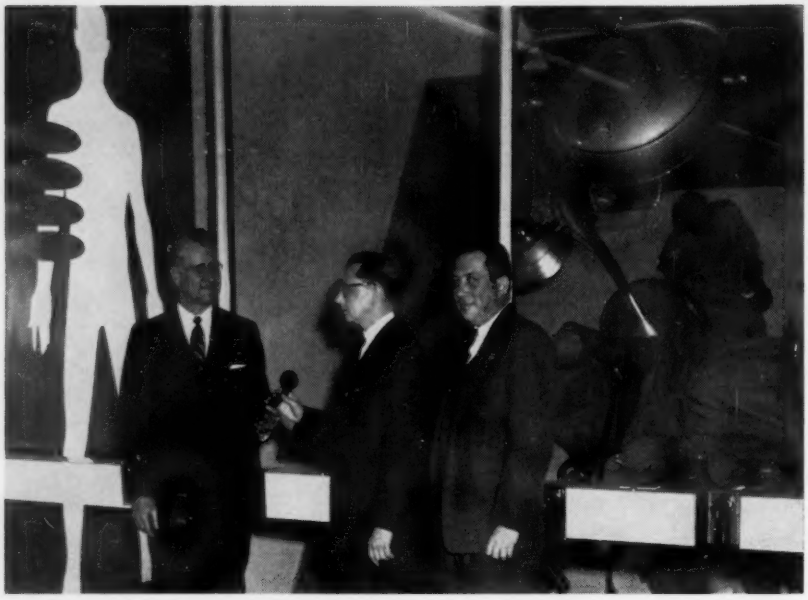
Write Department HB-5

AMERICAN STERILIZER COMPANY

ERIE • PENNSYLVANIA

DESIGNERS AND MANUFACTURERS OF SURGICAL STERILIZERS, TABLES AND LIGHTS

Personally Speaking



A new exhibit entitled "The Conquest of Pain, the Story of Anesthesia," was dedicated recently at the Chicago Museum of Science and Industry. The exhibit was prepared by the American Society of Anesthesiologists in cooperation with Abbott Laboratories. Standing in front of glassed-in operating room containing life sized models of surgery personnel at work are Dr. E. H. Volwiler, president of Abbott Laboratories, North Chicago (l.);B. B. Sankey, M. D., president of American Society of Anesthesiologists, Cleveland; and John Hunt, executive secretary, American Society of Anesthesiologists, Chicago.

E. A. Baber, M.D.—superintendent, Longview Hospital, Cincinnati, for the last 32 years, announced his retirement, effective June 30.

Olga C. Benderoff, R.N.—has been named to head nursing services and coordinate nursing education activities at City Hospital, Cleveland, O. Miss Benderoff was formerly chief of nursing service, VA hospital, Pittsburgh, Pa.

Jane Carroll—Vice President, Hoffman Advertising, Inc., New York City, will attend the 20th anniversary meeting of the International College of Surgeons, being held this month in Geneva, Switzerland.

Hazel Croom—has been appointed administrator, George County Hospital, Lucedale, Miss. succeeding **Cyrus E. Eaves.**

Oca Cushman—superintendent, Children's Hospital, Denver, for 45 years, has retired at the age of 85.

James Lewis Fieser—has been appointed administrator, Miners Hospital, Spangler, Pa. Mr. Fieser, a nationally known authority on public health service, was vice chairman of the National Red Cross from 1922 to 1945. He established the Red Cross Disaster Relief Service and was active in the development of the blood donor program.

Charles J. Greene—has been appointed superintendent, Norfolk (Va.) Community Hospital, succeeding **W. T. Mason.**

D. Andrew Grimes—has been appointed administrator, Greene County Memorial Hospital, Waynesburg, Pa. He succeeds **C. Kenneth Matthews,** who had served as administrator for the past eight years. Mr. Grimes formerly was administrative assistant, Vanderbilt University Hospital, Nashville, Tenn.

Mrs. Mildred Humphrey—has been named superintendent and housekeeper of the Clarion (Pa.) Osteopathic Community Hospital. The new position was created following the resignation of **Louis Chess,** hospital administrator. It was also announced that **Norma Jean Wise, R.N.,** has been appointed to head the hospital's nursing staff.

Samuel Janzen—has been appointed administrator, Valley View Hospital, Glenwood Springs, Colo. He formerly was administrator, Kiowa County Memorial Hospital, Greensburg, Kan.

Frank E. Kimble—has been appointed superintendent, Denver & Rio Grande Western Hospital, Salida, Colo., succeeding **Norma Clare,** who has resigned.

W. W. Lowrance—has resigned as administrator, Self Memorial Hospital, Greenwood, S. C., to become administrator, Memorial Mission Hospital, Asheville, N. C.

Frederick MacCurdy, M.D.—administrator, North Broward General Hospital, Fort Lauderdale, Fla. has announced his resignation. His successor is **Robert M. Gantt, Jr.**

Ernest C. McKay—administrator, Tampa (Fla.) Municipal Hospital has resigned. **Arthur G. Burns** has been appointed assistant superintendent there.

Vera J. Meeker, R.N.—has been named director, Hollywood (Calif.) Presbyterian Hospital. Miss Meeker formerly was director of nursing service and the School of Nursing, Deaconess Hospital, Spokane, Wash.

Jack Ruthberg, M.D. — formerly assistant director of Mt. Sinai Hospital, New York City, has been named administrator of the Northern Division of the Albert Einstein Medical Center, Philadelphia. Dr. Ruthberg succeeds **Franklin C. Fetter, M.D.,** who resigned to become medical director of the Philadelphia General Hospital.

Sister M. Johanna—is the new Sister Superior, St. Francis Hospital, Evanston, Ill. **Sister M. Stephanina,** who has been serving as both Superior and administrator, now will devote full time to administration.

Edmund D. Pellegrino, M.D.—has been appointed director, Hunterdon Medical Center, Flemington, N. J. The new director, who will continue as director of internal medicine at the center, succeeds **Ray E. Trussell, M.D.** Dr. Trussell resigned to accept a post at Columbia University School of Public Health and Administrative Medicine, New York City.

Stuart A. Shortt — administrator, Richland Memorial Hospital, Olney, Ill., has resigned. His resignation is effective June 30.

Lloyd G. Thompson—is the new administrator, Mandan (N.D.) Community Hospital.

Ralph W. Nelson—administrator of the Portland (Ore.) Sanitarium and Hospital since 1917, has resigned.

John C. Urbaitis, M.D.—has been appointed acting superintendent, Embreeville (Pa.) State Hospital. Dr. Urbaitis, who was assistant superintendent of Warren (Pa.) State Hospital, succeeds **Jess V. Cohen, M.D.** Dr. Cohen resigned recently.

Harry Wheeler—has been appointed administrator, Deaconess Hospital, Spokane, Wash., succeeding **Horace Turner,** administrator for the last 16 years. Mr. Wheeler formerly was administrator, Deaconess Hospital, Billings, Mont.

Charles W. Wilson—has been named administrator of the new Hempstead County Hospital, Columbus, Ark., which will open June 1. He is administrator of Clark County Hospital, Arkadelphia, Ark. at present.

Stuart Mount—has been appointed executive director, Nebraska Hospital Association, Lincoln. For the past two years, Mr. Mount has been assistant administrator of the University of Chicago Clinics.

Alvin B. Ortner, M.D.—has been elected president of the medical staff, Jewish Hospital, Louisville, Ky.

L. G. Parrish—has become superintendent, Clinton Memorial Hospital, St. Johns, Mich., succeeding **Chester E. Teske.** He formerly was superintendent, Memorial Hospital, Manitowoc, Wis.

Uiza Phillips—has been named administrator, Mahask Hospital, Oskaloosa, Ia. succeeding **Marvin Nichols** who resigned. He formerly was administrator, Sedgwick County Hospital and Clinic, Wichita, Kan.

Erwin J. Remboldt—was named administrator, White Memorial Hospital, East Los Angeles, Calif. For the past seven years he has been affiliated with the accounting and personnel offices of the hospital.

Anna D. Wolf, R.N.—director of the School of Nursing and Nursing Services, Johns Hopkins Hospital, Baltimore, will retire the end of June. Miss Wolf has become internationally known for her work in nursing education and nursing service in this country and in China, where she established the School of Nursing at Peking Union Medical College in 1924.

OUR 59th YEAR

WOODWARD *Medical Personnel Bureau*

FORMERLY AZNOE'S

3rd FLOOR, 185 N. WABASH AVENUE, CHICAGO 1, ILLINOIS

Ann Woodward *Director*

Founders of the counseling service to the medical profession, serving medicine with distinction over half a century.

POSITIONS OPEN

ADMINISTRATORS: (a) Medical; impor tch'g & research hosp; 425 beds; to $20,000; lge city. (b) Lay or Medical; impor ortho hosp affil, Mayo Foundation & impor med sch; replace man retiring after 24 yrs; E. (c) Lay; hosp 400 beds, tch'g unit impor med schl; req's man w/demonstrated ability; about $20,000; large city. (d) Medical; assistantship; 450 bed hospital; med sch affil; req's hosp adm exper; lge city; S-Central. (e) Lay; gen hosp 650 beds; med sch affil; W. (f) Medical; vol gen hosp, lge size; affi impor med sch; E. (g) Lay; new gen hosp 125 beds; planning expansion; working toward apprv'l; prefer mature person w/at least 2 yrs exper; attrac county seat twn; Central. (h) Lay; ass't; new post; 700 bed gen hosp, med sch affil; oppty succeed present adm few yrs; lge city. (i) Medical; 175 bed vol gen hosp; lge twn; E-coast. (j) Medical; gen hosp 250 beds; $12-$15,000; W-Mtn. (k) Lay; ass't; w/sev yrs exper & M.H.A.; gen vol hosp; appv'd JCAH: 300 beds; expansion prog; city 350,000; MW. (s) Lay; qual speak & write Spanish; 150 bed hosp, expand'g to 300; warm climate; outside continental U. S.

ADMINISTRATIVE EXECUTIVE POSTS: (a) Accountant; new 300 bed gen hosp; southern Canada. (b) Accountant; vol gen hosp, 285 beds; min $6000; good-sized coll twn; MW. (c) Bus Mgr; 90 bed gen'l hosp; attrac twn; W-Mtn. (d) Bus Mgr; sm gen hosp; to $6000; Great Lakes city; univ med center. (e) Bus Mgr; vol gen hosp, 250 beds; med sch affil; about $6500; univ city; S. (f) Comptroller; with supervisory exp in hosp accounting field; 800 bed tch'g hosp; E. (g) Comptroller; new 200 bed hosp; twn 85,000; SE. (h) Comptroller; 275 bed, vol gen hosp; coll twn, large trade drawing area; Central. (i) Credit Mgr; vol gen hosp, 300 beds; coll twn, 100,000; MW. (j) Ofc Mgr; especially qual in credit & collection; vol gen hosp, 100 beds; attrac twn, nr lge city, MW. (k) Personnel dir; lge size gen hosp; attrac coll twn; E-coast. (l) Purchasing dir; 300 bed vol gen hosp; coll twn; 100,000; MW.

ADMINISTRATORS—WOMEN: (a) Lay or R.N.; exp'd in opening new hosp; 150 bd hosp; about $7200; So. (b) RN, sm gen hosp; sal & full mtce; agric area; MW. (c) Lay or RN; must speak & write Span; 150 bd indus hosp; attrac foreign location. (d) Lay or RN; 100 bd gen hosp, 2 yrs old; excel educ, cultural ctr; W-central. (e) Lay or RN; 40 bd gen hosp now under constr; attrac twn; M W.

SITUATIONS WANTED

ADMINISTRATOR: B.S. (Bus Adm) M.S. (Hosp Adm); year's adm residency, 700 bed hosp; seeks directorship, hospitals 50 to 100 bds; preferably southeast; fine appearing; well-trained, competent; late 20's.

ADMINISTRATOR: Medical; degree, impor sch; nine years teaching medicine; 5 yrs; medical director, tch'g hosp.

ADMINISTRATOR: Woman RN; late 40's; FACHA; 17 yrs admin exp, 12 in same 80 bd gen hosp; seeks similar appt; E only.

ASSISTANT ADMINISTRATOR: 29, married (o); B.A., M.S., Public Health, Yale Medical; seven years, USAMC; drafted to 1st Lt; clinical & administrative duties; both wars; recall unlikely; finishing year's hosp adm residency; seeks hospitals 100 to 300 beds; consider administrative assistantship; lge hosp; any locality.

ANESTHETIST: reg'd; 20's; colored; 2 yrs anes exp; excel refs; Calif only, pref Los Angeles.

CYTOTECHNOLOGIST: female; single, 30's; trng rec'd Cornell U; 8½ yrs exp, 6 as chief tech, gyn & path lab, lge univ hosp; 1½ yrs exp teach'g & rsrch asst, Eastern univ; seeks chief or teach'g posi; MW only.

DIRECTOR OF NURSES: MS admin in schools of nurs, Catholic U; single; 50's; 6 yrs exp as OR super; 7 yrs teach'g exp; 8 yrs, instr & asst DofN, 250 bd hosp; 1½ yrs, same capacity; 350 bd hosp; seeks directorship or asstship; Ga only, pref nr Atlanta.

EXECUTIVE HOUSEKEEPER: late 30's; 3 yrs exp, exec hskpr, 80 bd gen hosp & ancillary bldgs; seeks similar posi, sm hosp pref; SW only.

MEDICAL RECORD LIBRARIAN: reg'd; early 30's; 13 yrs exp, 12 as asst, 600 bd gen hosp; seeks chief posi, Washington, DC, only.

NURSE ANESTHETIST: reg'd; 50's; nearly 16 yrs anes exp; pref 8-hr shift, OB anes only; Deep So. only.

PATHOLOGIST: 38; trained univ hospitals; Board elig, anatomical & clinical path; four years' priv gen practice before specializing; currently associate pathologist 350 bed hospital.

PHYSICAL THERAPIST: female, reg'd, late 40's; M.A. in phy educ; 25 yrs exp, 12 as chief, various gen & army hosps; Calif only; avail Nov, '55.

PURCHASING DIRECTOR: A.B.; excel exper in credits & accounting; 5 years Lt. Comdr., USN; 3 years ass't purch dir, lge univ hosp; member, Purch Agents Assn, Am Hosp Assoc; middle 30's; avail 2 mos; seeks hospital 400 beds up.

RADIOLOGIST: 30, Diplomate, diagnostic & therapy; trn'd univ hospitals; currently radiologist, 300 bed hosp; seeks directorship; dept radiology, hosp in south, southeast or southwest.

VA Appointments

Alex M. Burgess, M.D.—has resigned as area chief of medicine, VA, Washington, D. C. He has been appointed director of medical education, Newport (R. I.) Hospital and Providence (R. I.) Hospital.

Amerigo P. Dell Cort, M.D.—chief of professional services, VA neuropsychiatric hospital, Lexington, Ky., has been promoted to manager. He succeeds **Frederick M. Cook, M.D.,** who retired recently.

Thomas T. Frost, M.D.—has been appointed chief of pathology service,

(Continued on next page)

North Little Rock (Ark.) VA hospital. He has been chief of laboratory service, VA Center, Whipple, Ariz.

Michael L. Matte, M.D.—formerly manager of the Denver (Colo.) VA hospital, has been transferred to manage the VA research hospital, Chicago. Dr. Matte succeeds **William W. Fellows, M.D.**, who has been promoted and transferred to Washington, D. C. as Assistant Chief Medical Director for Planning in the VA Department of Medicine and Surgery. Replacing Dr. Matte in Denver is **Harold M. Engle, M.D.**, present manager of the VA hospital, Salt Lake City, Utah. **Thomas O. Lake, M. D.**, chief of professional services, Oakland (Calif.) VA hospital, has been promoted to manager of the Salt Lake City hospital replacing Dr. Engle.

Howard P. Morgan, M.D.—has been appointed manager, VA hospital, Fort Lyon, Colo. Dr. Morgan had been chief of professional services, Roanoke (Va.) VA hospital.

Daniel R. Robinson, M.D.—formerly chief of professional services, Indianapolis (Ind.) VA hospital, has been appointed manager Dwight (Ill.) VA hospital.

A. W. Woolford—has been named manager, Jackson (Miss.) VA hospital. He formerly was manager of the VA hospital of Montgomery, Ala. He was succeeded by **John S. Herring, M.D.**

MARY A. JOHNSON
ASSOCIATES
AGENCY

11 West 42 Street, New York 36
Lackawanna 4-1565

Mary A. Johnson, Ph.D., Director

Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven method shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

No registration fee

Deaths

Donald A. Bourne—63, administrator of Hawthorne (Calif.) Community Hospital, died March 2.

Edward Bennet Close—73, former managing director of the American Hospital, Paris, France, died in early February. Mr. Close became manager of the hospital in 1935 and continued the hospital's direction through the first year of the German occupation.

Arthur Spear Hartwell, M.D.—85, one of the founders of Norwood (Mass.) Hospital and chief surgeon there for many years, died February 26.

Adolph Magnus-Levy, M.D.—90, eminent medical scientist who was a pioneer in the field of metabolism, died early in February. Dr. Magnus-Levy was the first to introduce the method of determining basal metabolism. He also did pioneer work on diabetes.

Paul O'Hara—52, former head of the Vauclain Home tubercular wing of San Diego (Calif.) County Hospital, died February 12.

Dorothy Platt, R.N.—67, director of nurses, St. Mary's Hospital, Bayside, L. I., died February 24.

Stephen L. Polyak, M.D.—65, professor of anatomy at the University of Chicago and internationally known authority on the anatomy of the eye, died March 9. Dr. Polyak had just finished a new volume, *The Vertebrate Visual System.*

Rev. Mother St. Claire—67, administrator, St. Mary's Hospital, Kankakee, Ill., died March 4. She had been associated with the hospital since 1911 and was named administrator in 1936.

Sister Mary Louis Catherine—administrator, St. Mary's Hospital, Jefferson City, Mo., died February 12.

Benjamin W. Seaman, M.D.—70, died February 10. A report he wrote on hospital needs in Long Island, N. Y., was largely responsible for the subsequent founding of the North Country Community Hospital, Glen Cove, N. Y., South Nassau Communities Hospital, Oceanside, N. Y.; Long Beach Memorial Hospital and Meadowbrook Hospital, Hempstead, N. Y.

Albert W. Seidel, M.D.—74, administrator, Walther Memorial Hospital, Chicago, died April 3. He was past president of the National Lutheran Hospital Association.

CLASSIFIED

SHAY MEDICAL AGENCY

Blanche L. Shay, Director

Pittsfield Bldg., 55 E. Washington St.

Chicago 2, Illinois

POSITIONS OPEN

EXECUTIVE PERSONNEL: (a) Business Manager. West. 85 bed hospital; good hunting and fishing, close to several National Parks. (b) Business Manager. East. 25 man group, well established, excellent opportunity. $8000. (c) Personnel Director. Middle West. Large hospital. Require good training plus experience in hospital personnel. $8000. (d) Comptroller. Middle West. 400 bed hospital. At least 3 years experience in accounting a business management. $7000. (e) Personnel Director. East. Able to set up department. Real opportunity. $5000 minimum to start. (f) Office Manager. East. 110 bed hospital. 5 years experience in hospital business office. Excellent opportunity.

PHYSICAL THERAPISTS: (a) Southwest. 125 bed hospital. Training in handling polio patients. $500. (b) Southwest. 225 bed hospital located in college town. Ideal working conditions; modern well equipped department. $400 minimum to start. (c) East. 200 bed hospital located in beautiful New England college town. (d) East. 500 bed hospital. 10 employees in department. (e) Southwest. New hospital; all new equipment in therapy department. Excellent opportunity. $400 minimum to start.

EXECUTIVE HOUSEKEEPERS: (a) South. 300 bed hospital; 2 assistant housekeepers and 53 employees in department. (b) East. 225 bed hospital; 60 employees in department. Located in city of 25,000 easily accessible to New York and Boston. (c) Middle West. 200 bed hospital in pleasant college town. Experience in interior decorating would be helpful. (d) Pacific Northwest. 350 bed general hospital. 50 employees in department. (e) 400 bed hospital. Medical center type hospital affiliated with University. Require good experience and ability to completely set up department. Will consider man or woman. This is an unusually fine opportunity.

Clarence G. Smith—59, assistant director and comptroller, Cleveland Hospital Service Association, died March 13. Mr. Smith was widely known for his studies of hospitalization statistics.

William G. Sodt—61, retired administrator, Milwaukee (Wis.) Hospital, died February 23. Mr. Sodt was a member of the board of the Lutheran Hospital Association of America.

Rev. Paul R. Zwilling—71, retired administrator, Deaconess Hospital, St. Louis, Mo., died in March. He was a past president of the American Hospital Association.

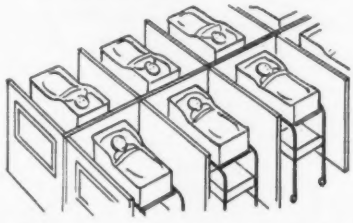
WANTED: Salesmen calling on hospitals to sell hygienic bed spring covers as side line on liberal commission basis. Hygienic bed spring covers, at low cost, insure against torn sheets, snagged mattresses, infiltration of floor dust among other good features. Alone in its field. Most territories open. One sample to carry. Seelig Specialties Co., 223 N. Peters St., New Orleans, La.

New 2-Way BASSINET

1. FOR ROOMING-IN TECHNIQUE
   or
2. FOR CUBICLE ARRANGEMENT IN NURSERY

ROOMING-IN TECHNIQUE

The bassinet is wheeled from the nursery to the mother's room. The entire unit is light in weight and moves easily on rubber-tired swivel casters. Extra-long extension base slides under bed, brings basket and supplies within easy reach for mother to work on infant.



CUBICLE TECHNIQUE IN NURSERY

Self-contained bassinet holds all necessary equipment for individual attention. Basket, utensil holder and shelf are conveniently accessible. Light weight and simplicity of design aid flexibility of arrangement. Unit takes up minimum amount of space, gives nurse ample working area.

REMOVABLE PLASTIC BASKET — Light weight and sanitary. All corners and edges are rounded. Basket can be tilted at either end. Has name-card holder.

UTENSIL HOLDER is portable and can be attached to either side of stand within easy reach of mother or nurse. Metal containers hold cotton balls, oils, swabs, and other supplies.

SHIELDED SHELF holds linens, diapers, blankets, etc. Welded to stainless steel tubular uprights. Inside corners rounded to facilitate cleaning.

EXTRA-LONG EXTENSION BASE — designed to slide under bed. Brings basket and accessories within easy reach for mother to work on infant.

BOYLSTON Model STAINLESS STEEL BASSINET with Plastic Basket

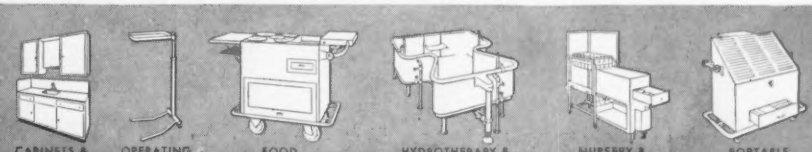
• Whether your institution employs rooming-in technique or cubicle nursery arrangement, this low-cost stainless steel bassinet serves either with utmost safety and facility. All necessary supplies are within convenient reach of nurse or mother. Simple in design, of sturdy, welded construction, the bassinet is easily cleaned and sterilized. There are no painted surfaces to chip or crack, no dirt-collecting joints or crevices. Here is a Blickman-Built unit priced to meet your budgetary requirements — yet so durable that it virtually eliminates maintenance or repair costs. Write for further information.

SEND FOR OUR CATALOG 11-NEC

• Illustrates and describes many other units of Blickman-Built equipment for nursery and pediatric departments, as well as for milk formula rooms.

S. Blickman, Inc., 5705 Gregory Avenue, Weehawken, N. J.

Blickman-Built
Hospital Equipment



You are welcome to our exhibit at the Catholic Hospital Association Convention, Kiel Auditorium, St. Louis, Mo., Booths No. 200-204, May 16-19, and to the Middle Atlantic Hospital Assembly, Convention Hall, Atlantic City, N. J., Booths No. 314-316, May 25-27

SYNKAYVITE

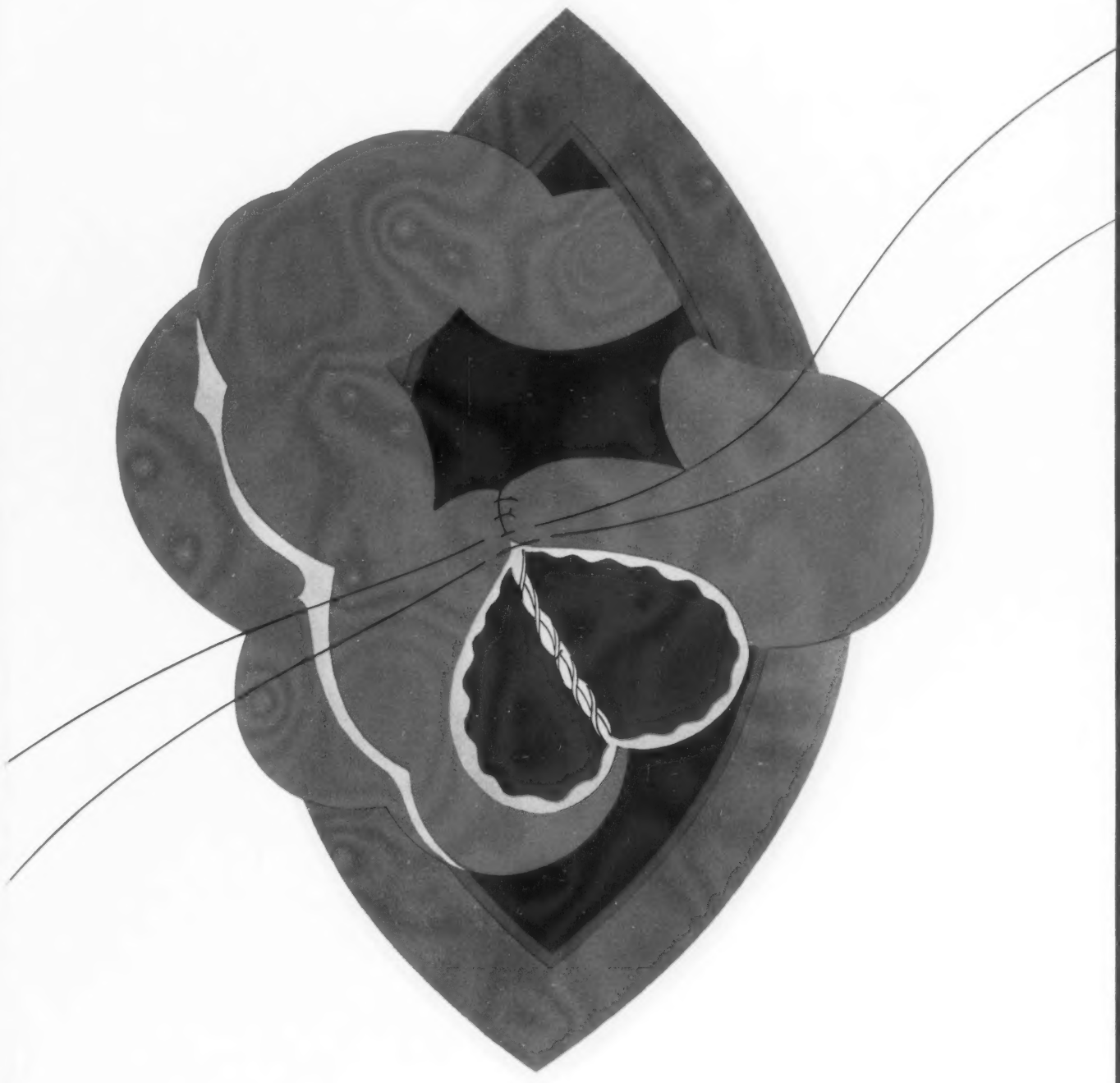
In hospitals throughout the country, orders for routine administration of vitamin K often specify Synkayvite 'Roche.' Water-soluble, highly potent and economical, Synkayvite is suitable for subcutaneous, intramuscular, intravenous and oral therapy. Synkayvite will not gather dust on your pharmacy shelves.

SYNKAYVITE®

Synkayvite Sodium Diphosphate – brand sodium menadiol diphosphate

ORDER DIRECT FROM 'ROCHE' AT HOSPITAL PRICES.

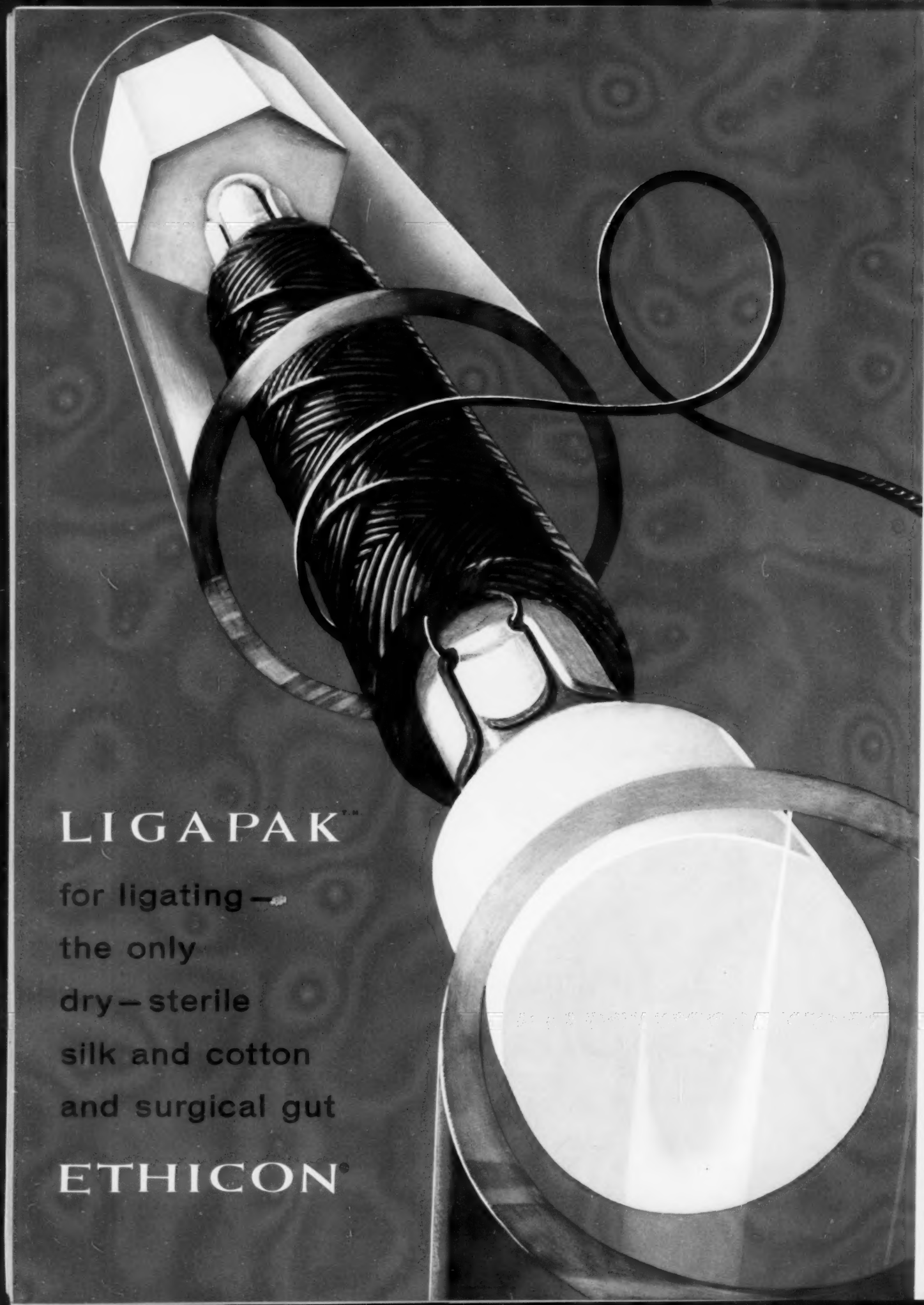
HOFFMANN - LA ROCHE INC.
Roche Park • Nutley 10 • New Jersey



setting new standards

ETHICON®

sutures


LIGAPAK™
for ligating—
the only
dry—sterile
silk and cotton
and surgical gut
ETHICON®

THE LAB

Massachusetts M.T.'s Meet in Springfield

The annual seminar for Massachusetts medical technologists was held at the Springfield (Mass.) Municipal Hospital March 26 and 27.

The program, planned by Phila Vaill, M.T. (ASCP), of the Springfield Hospital, included discussions, demonstrations of technics, and new instruments, lectures, and movies.

Howard P. Kennedy, M.D., trustee, Springfield Municipal Hospital, discussed "Rheumatic Fever: the Patient and the Laboratory." Mrs. Edith Reinisch, M.T. (ASCP), bacteriologist, Westfield (Mass.) State Sanatorium, who spoke on "The Use of Blood Media for the Routine Cultivation of M. Tuberculosis," introduced statistical comparative findings on the results of recent experiments in which she cultivated the tubercle bacillus on blood agar, penicillin blood agar, Petrogani's media, and Lowenstein's media.

William A. Godfrey, Springfield attorney, pointed out that there are several phases of medical technologists' work which may demand a knowledge of legal aspects. The uses of radioactive iron in iron metabolism were discussed by William N. Davis, M.D., Springfield, specialist in internal medicine and hematology. Maj. Thomas B. Smith, chief, clinical and medical laboratory, 1600th USAF Hospital, Westover (Mass.) AFB, talked about "Diagnostic Methods for Parasites of Medical Importance in New England."

Mrs. Eleanor Judd, M.T. (ASCP), medical technologist in charge of the laboratory at the Robert Breck Brigham Hospital, Boston, discussed proposed state legislation affecting medical technologists, and William Kaufman, M.D., chief pathologist, Springfield Hospital, told the reasons behind and the importance of tests performed on the flame photometer.

Other speakers and their subjects were: Sister Mary Aloysius, S.P., instructor, Mercy Hospital, Springfield, "Technic and Theory of 17-Ketosteroids"; Pliny Allen, M.D., pathologist, North Adams (Mass.) Hospital, "Unusual and Interesting Autopsy Findings"; and Ellsworth Twible, M.D., Springfield, "Problems of the Rh Factor."

Representatives from the General Scientific Equipment Co. demonstrated the use of new instruments for (1) a rapid polarographic method for determination of lead, arsenic, copper, and 17-ketosteroids; (2) platelet counts using phase contrast; (3) the Petrological microscope in the examination of normal and morbid tissue; (4) the determiniation of blood pH; (5) automatic projection weighing, and (6) flame photometry.

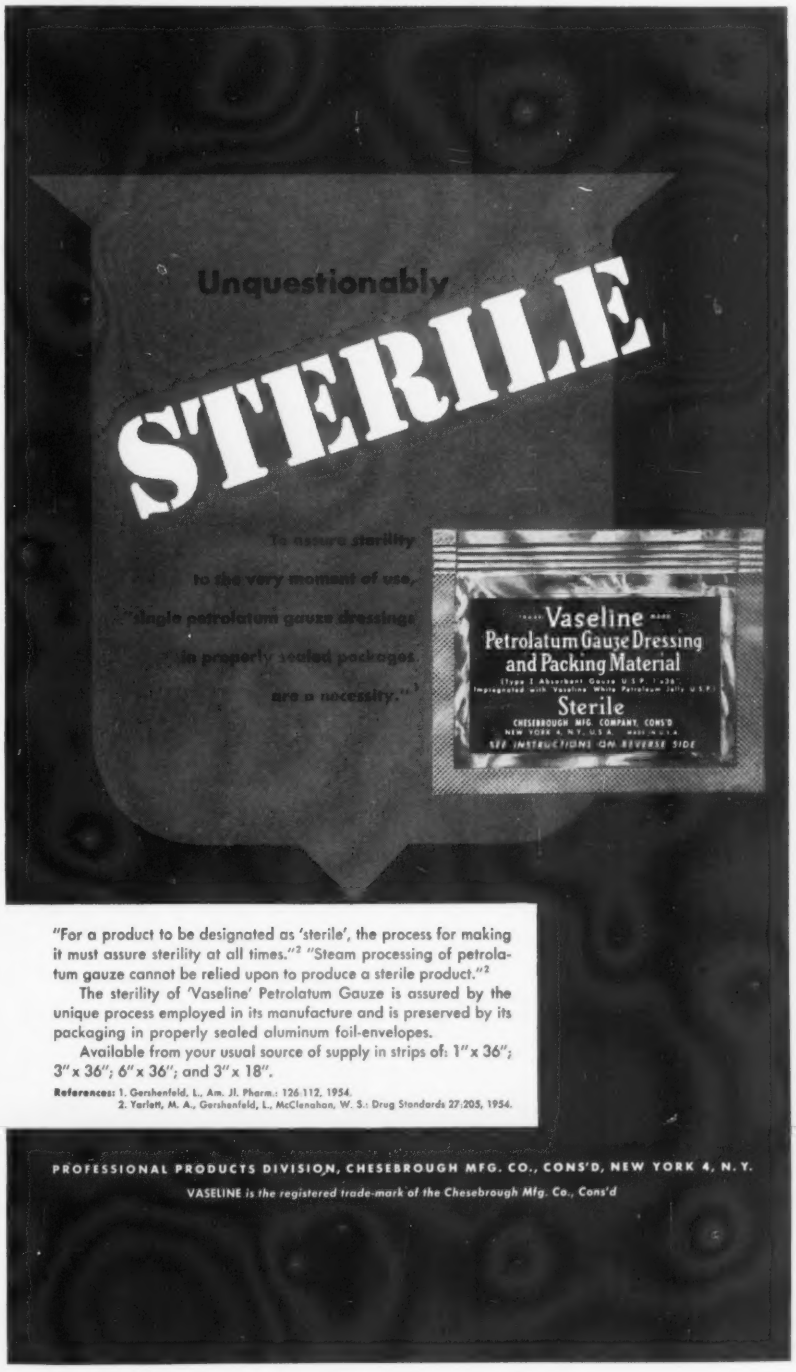
Dorothy Lozoski, M.T. (ASCP), was general chairman of the seminar.

Blood Banking Course Held in St. Louis

A one-week refresher program in blood banking, sponsored by the medical technology committee of the Catholic Hospital Association, was held April 25-29 at the Wohl Health Center, St. Louis, to assist technologists to prepare for examination for certification as blood bank technologists.

The examination will be given May 13 by the American Association of Blood Banks and the Board of Registry of Medical Technologists of the

(Continued on page 71)


Unquestionably
STERILE
To assure sterility to the very moment of use, single petrolatum gauze dressings in properly sealed packages are a necessity.[1]
Vaseline
Petrolatum Gauze Dressing and Packing Material
Sterile
CHESEBROUGH MFG. COMPANY, CONS'D
SEE INSTRUCTIONS ON REVERSE SIDE
"For a product to be designated as 'sterile', the process for making it must assure sterility at all times."[2] "Steam processing of petrolatum gauze cannot be relied upon to produce a sterile product."[2]
The sterility of 'Vaseline' Petrolatum Gauze is assured by the unique process employed in its manufacture and is preserved by its packaging in properly sealed aluminum foil-envelopes.
Available from your usual source of supply in strips of: 1" x 36"; 3" x 36"; 6" x 36"; and 3" x 18".
References: 1. Gershenfeld, L., Am. Jl. Pharm.: 126:112, 1954.
2. Yarlett, M. A., Gershenfeld, L., McClenahan, W. S.: Drug Standards 27:205, 1954.
PROFESSIONAL PRODUCTS DIVISION, CHESEBROUGH MFG. CO., CONS'D, NEW YORK 4, N. Y.
VASELINE is the registered trade-mark of the Chesebrough Mfg. Co., Cons'd

TRADE TOPICS...

Royal Metal Acquires Frank A. Hall, Inc.

The Royal Metal Mfg. Co., Chicago, metal furniture manufacturer, has acquired the business and assets of Frank A. Hall, Inc., New York City manufacturer of hospital furniture. The new firm will function as Frank A. Hall, Inc., a division of Royal Metal Mfg. Co., under the same officers as the parent company. Sales will be under the direction of Alfred E. Siegel, sales manager of Royal's hospital-contract division.

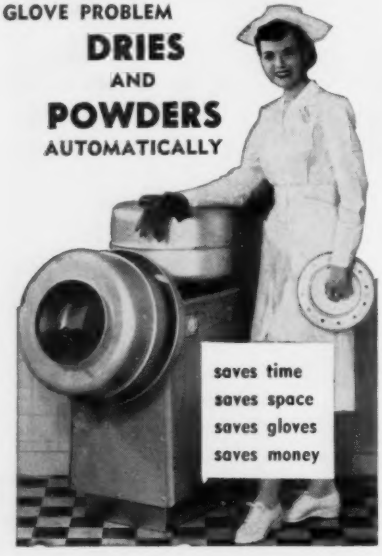
This merger does not include the Frank A. Hall and Sons Co., New York City, which will continue to manufacture mattresses and bedding under the original owners, as a separate and independent corporation.

Wilmot Castle Moves

Wilmot Castle Co. has moved its factory and general offices to a new plant at 1777 E. Henrietta Rd., Rochester, N. Y. The modern, one-story building houses greatly increased production facilities and testing laboratories.

SOLVES YOUR GLOVE PROBLEM

DRIES AND POWDERS AUTOMATICALLY



If you are interested in cutting costs, and doing the job in a SMALL FRACTION OF THE TIME hand methods require, write today for particulars.

- Ask about our Rental-Purchase Plan

The GloveMaster

E. M. RAUH & CO., Inc.

2 PARKER AVE. BUFFALO 14, N. Y.

Lederle Laboratories Appoints Miss Rietz

Jane Rietz has been named associate director of medical technology for Lederle Laboratories Division, American Cyanamid Co. Miss Rietz will maintain liaison on the professional level with technologists at hospitals and diagnostic laboratories.

American Hospital Supply Corp. Announces Personnel Changes

Paul D. Scheele has been named sales manager for the seven-state Chicago Division of the American Hospital Supply Corp. Succeeding him as sales representative in Chicago, northern Indiana and southern Michigan, is Robert H. McCulloch.

The company also has announced the appointment of George Leys as assistant division manager of its Atlanta Division, Chamblee, Ga.

Dewey H. Palmer Joins Clay-Adams

Dewey H. Palmer is the new director of product development, Clay-Adams, Inc. Since 1941 Mr. Palmer has been director of research for the Hospital Bureau of Standards & Supply. He has represented the American Hospital Association in establishing quality standards on a number of medical products and is currently chairman of the A.H.A. Committee on Simplification and Standardization.

Since 1948, Mr. Palmer has been conducting courses at Columbia University, New York City, in institutional management, including quality standards on medical and surgical supplies.

New Plant for American Safety Razor

Production of American Safety Razor Corporation's Hospital Division products is nearing full scale operation at the company's new Staunton, Va. plant, according to Sidney Weil, president.

Improved laboratory and engineering facilities will enable the company to expand its product development program.

Propper Appoints New Director of Product Development

Irving Speelman has been appointed director of product development for Propper Manufacturing Co., Inc. He will not only be in charge of development of new products but also direct a program of research on improvement of present products.

Mr. Speelman was engineering chief, Specifications Department, Medical and Surgical Instruments and Diagnostic Equipment, in the Armed Services Medical Procurement Agency.

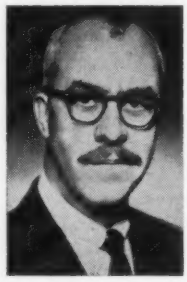
Lilly Vice-President Announces Retirement

Carl F. Eveleigh, executive vice-president, Eli Lilly & Co., Indianapolis, Ind., is retiring after 42 years of service. He had been executive vice-president since 1948.

Joseph A. Cappucci Forms Own Firm

Joseph A. Cappucci has severed his business connections with Huntington Laboratories, Inc., to establish the firm of Cappucci Brothers, 885 Flatbush Ave., Brooklyn 26, N. Y. The new company will handle a complete line of hospital and institutional sanitation products.

Sales Organization Changes Made at Bristol



Bristol Laboratories, Syracuse, N. Y., has announced several changes in its sales organization. Harlow C. A. Walker (pictured at right) has been appointed director of sales training. In this capacity he is responsible for the training of company representatives in the field and at sales conferences.

In addition, three sales representatives have been promoted to district managers. They are: William C. Schmidt, headquartered in Syracuse, N. Y.; Leland G. Close, Atlanta, Ga.; and Earl W. Peck, Cleveland, O.

(Continued on page 68)

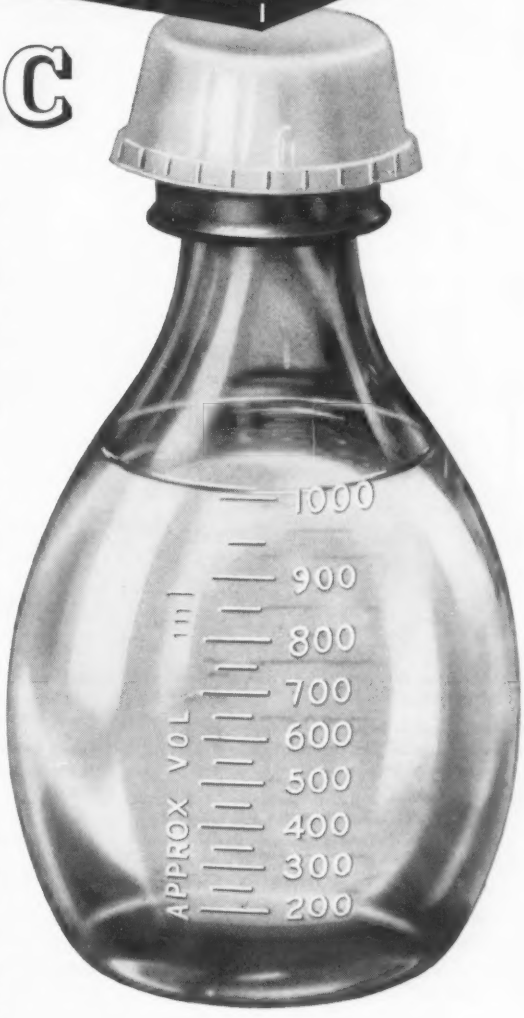
MACALASTER BICKNELL
Parenteral Corporation
CAMBRIDGE 39, MASSACHUSETTS

Introduces

Improved SELF-SEALING

POUR-O-VAC

The Macalaster Bicknell Research Laboratory presents a significant improvement in the Pour-O-Vac Technique, already America's most widely used sterile fluid flasking method.



★ **MODIFIED SELF-SEALING CAP MAY BE UTILIZED WITH EXISTING POUR-O-VAC COLLARS AND FLASKS.**

This new self-sealing cap is of pure nylon, and virtually indestructible. The one-piece moulded nylon cap is light, easy to handle, and provides mechanically for approved aseptic technique because it has no hard-to-clean recesses. Placed on the container before sterilization, it is held in place during sterilization, then automatically seals itself by vacuum at the end of the sterilization cycle.

★ **SPECIAL RUBBER COMPOUND COLLAR UNMATCHED FOR WEAR — and it's ODORLESS!**

The utility of the efficient and unique patented design of the Pour-O-Vac Collar has been still further improved. Macalaster Bicknell and affiliate engineers have now perfected a resilient odorless compound which will withstand almost endless wear and exposure to high temperatures. This new compound used in the ridge and groove-free Pour-O-Vac Collar sets a new record of achievement.

★ **PREFERRED PEAR-SHAPE FLASK — PROVEN STRUCTURALLY STRONGER BY GLASS MOULDING PRINCIPLES.**

Macalaster Bicknell Company's pear-shaped Pyrex flask is structurally the strongest and safest glass container for sterilizing fluids known to science. Glass bottles are really bubbles blown of liquid glass inside an iron mould. The more the mould distorts the shape of a natural bubble, the more weak spots the final container acquires. Compare the shape of Macalaster Bicknell's flask with the shape of a hanging drop of liquid. There is the secret of the unchallengeable natural forces which make this pear shape flask so near theoretical perfection.

ORIGINAL DISTRIBUTORS OF THE FENWAL SYSTEM

How Others Do It

There are thousands of worthwhile ideas adopted by hospitals each year which save untold dollars and which reduce cost of patient care. HOSPITAL TOPICS *will pay $10 for each idea published in this column. Simply write your idea, enclosing a rough sketch or photograph if necessary, and mail to "How Others Do It" Editor, Hospital Topics, 30 W. Washington St., Chicago 2, Ill.*

It's New! **HOHM NEUROSURGICAL INSTRUMENT TABLE**

Designed by a neurosurgical scrub nurse for use by surgeon, scrub nurse and anesthetist. Easily adjustable in height and wide enough to pass over the operating table. Permits adequate exposure of the patient.

Check These Advantages:

1. Eliminates the need of two instrument table setups.
2. Is adjustable in height (48 in. to 60 in.) by means of precision cut gears, elevated by a hand crank.
3. The table top is 18 in. wide by 31 in. long, which is adequate for large instrument setups. 29 inches between uprights.
4. Table top is constructed of heavy gauge stainless steel—easily cleaned. Base and uprights are of polished aluminum.
5. Used to advantage in other type of surgery — such as mastoidectomy, chest surgery.
6. Table is immobilized with foot controlled, 4 in. conductive lock type casters.

DRAPING OF TABLE AND PATIENT

Hand or special towels for skin drapes.
Double thickness half sheet placed on the neuro table.
Full length head sheet unfolded over neuro table and carried down to cover patient.
(Two half sheets may be used to reinforce head sheet at head of table).

Manufactured by

CHAS. A. SCHMIDT SURGICAL INSTRUMENT CO., INC.

Incorporated 1917

Manufacturers of ORTHOPEDIC SPECIALTIES

3689 OLIVE STREET • JEfferson 3-4662 • SAINT LOUIS 8, MISSOURI

New Use for Empty Solution Boxes

● For years we burned empty solution boxes in the incinerator thinking there was no use for them. Now we have found them useful, as well as a money and time-saver.

We had our plant engineer construct open-end plywood boxes into which these solution boxes could be inserted as disposable waste receptacles. Since the containers are of double thickness, they have proved to be entirely safe and satisfactory for wet dressings, etc. To empty, the housekeeping staff merely pulls out the containers, with their contents, and places them in the incinerator.

With these inserts, we no longer have to scrub waste cans or buy expensive new receptacles.

Submitted by Norman C. Lisk
Administrator
Chatham Hospital, Inc.
Siler City, N. C.

Elastic for Open Back Hospital Gowns

● The following is an idea for making "open-back" hospital gowns more comfortable.

Instead of using the customary tape ties at the neck in the back of the gown, we sew a piece of one-inch-wide belt elastic, two or two-and-a-half inches long, to both sides of the back of the gown at the neck. This eliminates the lump and wrinkles made when ties are used, making it more comfortable for the patient.

Since the elastic is not torn off as readily as ties are, it is also a help in the laundry process, thus increas-

(Continued on page 71)

ing the lifetime of each garment.

With the elastic, it is necessary to slip the gown over the patient's head. Since the open gowns usually are quite large, however, this is easily done.

The inch wide elastic is quite soft and retains its elasticity after many washings. The kind used for skirts and dresses is more desirable than the heavier types used for straps, etc. It can be purchased at any notion department for 20 cents a yard.

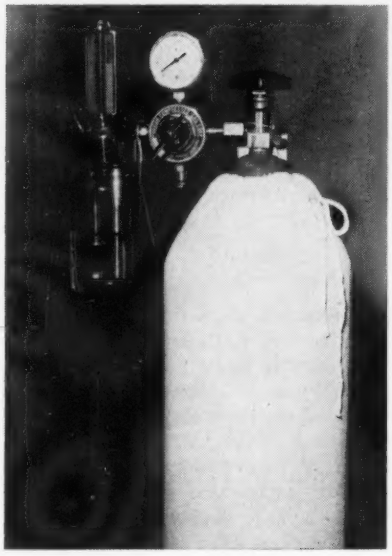
Submitted by Sister Rita Mary, R. N.
General Duty Nurse
Villa Maria Infirmary
Wernersville, Pa.

Stocking Cap for Oxygen Tanks

● Holzer Hospital, Gallipolis, O., has devised a stocking cap for oxygen tanks for the purpose of improving aseptic technic, creating a neater appearance (paint on outside of tanks frequently cracks and rusts), and reducing noise of handling.

The method is as follows: A stockingette is used, 12 inches wide by 60 inches long. A small hem is made in the bottom and in the top. A drawstring is inserted in the top hem to keep the cover in place on the tank.

Prior to delivery to the patient



area, all tanks are cleaned on the outside, the stockingette is put in place, and the gauge is inserted.

Submitted by Wayne B. Foster
Administrator
Holzer Hospital
Gallipolis, O.

Marie H. G. Charlier Receives New Promotion

Marie H. Charlier, R.N., Ph.D., has just been promoted to the position of principal chief nurse, New Jersey Military District. No successor has been appointed yet to her previous assignment as Operating Room Supervisor, 322nd General Hospital. She succeeds Major Helen M. Atkinson.

Major Charlier is the author of *Institutional Problems and the Nursing Team,* which appeared in the April issue of HOSPITAL TOPICS.

Connecticut Association Sponsors Accounting Workshops

The Connecticut Hospital Association is planning a series of four one-day workshops on uniform expense accounting and interpretation of cost analysis. To be held May 6, 13, 20 and 26 at Berlin, the sessions will be conducted by the CHA Council on Administrative Practice and the Connecticut chapter of the American Association of Hospital Accountants. The tuition free workshops are open to governing board members, administrators, public accountants, controllers, expense and stores distribution clerks, accounts payable clerks and other hospital office personnel.

When you think of Sutures, think of –

DEKNATEL

STERILE PACKED

SURGICAL GUT
plain – medium chromic – extra chromic

READI-CUT Surgical Silk and Cotton
dry sterile cut lengths
with Col-R-Tips to identify size

NON-STERILE

SPOOLS of Surgical Silk, Cotton, Nylon and Stainless Steel

READI-CUT Surgical Silk and Cotton
cut lengths wound on metal reels

READI-WOUND Surgical Silk and Cotton
machine wound to prevent kinking
on flexible rubber reels

All Sutures available with swaged-on DEKNATEL stainless steel MTN (Minimal Trauma Needles)

J. A. DEKNATEL & SON INC.
Queens Village 29, N. Y.

The Book Corner

Hospital Emergency Defense

By Lt. Robert McGrath, Hospital Inspector, Chicago Bureau of Fire Prevention. Reproduced for the Chicago Fire Department by The Chicago Civil Defense Corps. 26 pages, plus illustrations. This is at present a limited edition of 1,000 copies, which has been distributed to hospitals in the Chicago area and to various other hospitals. In submitting it for review, Lt. McGrath states that if enough hospital people feel that the material answers some of the institutional safety problems it will be submitted to a publisher and additional pages and illustrations will be added.

Numerous requests for the book have been received from all sections of the country, following publicity given by metropolitan newspapers and such magazines as HOSPITAL TOPICS and *The Modern Hospital*, according to James E. Collins, Division Marshal in charge of the Bureau of Fire Prevention in Chicago.

The aim of the book is to aid the hospitals which are not satisfied with their present fire emergency program. In the words of the author, the fire department is particularly interested in personnel activity during the two or three minutes before the arrival of the first fire company.

Early in the book the author explodes the myth, "This is a fireproof hospital." His next task is to dispel fear, which arises from self-preservation as well as the preservation of others. The best answer to this problem is to learn what to do when the emergency does arise.

First in importance is removal of the patient. This is discussed in considerable detail, with photographs illustrating the various steps. Evacuation of the hospital is also given prominent attention, and the difference between hospital evacuation and that of schools and factories is stressed.

This splendid discussion of an extremely important problem should be not only read but also studied at periodic intervals by all hospital personnel.

If you would be interested in having it available in book form, you may drop us a line and we will convey the information to the author, or you may write him direct.

Antibiotics and Antibiotic Therapy

By Allen E. Hussar, M.D., F.A.C.P., and Howard L. Holley, M.D., F.A.C.P. Published by the Macmillan Company, New York. 475 pages. This book is directed to those in clinical practice rather than the bacteriologist who is working with antibiotic agents. It is written entirely at the clinical level.

The book is divided into three parts: the fundamentals of antibiotic therapy; antibiotics in clinical use, and the drug of choice. Part 3, which constitutes more than half the book, discusses diseases by organism and by anatomical group, and gives the drug or drugs indicated in each instance. Dosage and duration of treatment are included, as well as other treatment methods. For discussion of the drugs themselves, the reader is referred to Part 1 and Part 2.

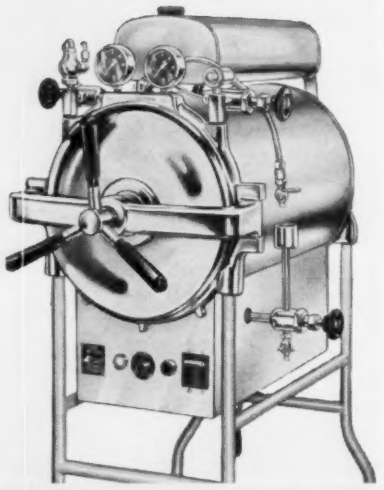
This is indeed a useful book to have for reference once the diagnosis has been made, as well as for study.

HERE'S IDEAL STAND-BY EQUIPMENT FOR EVERY HOSPITAL AND CLINIC

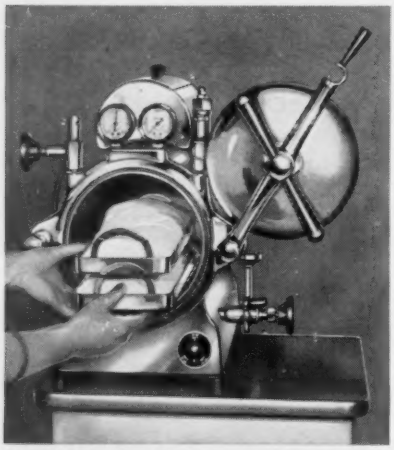
With a Pelton self-contained autoclave adjacent to your operating room, you are ready for fast sterilizing of instruments in any emergency. After the autoclave is in operation, you can sterilize uncovered instruments in only three minutes by turning the pressure dial to 27 lbs. or 267° F. Muslin-covered instruments are safely sterilized in 10 minutes at 250° F.

LV-2 AUTOCLAVE

The Pelton LV-2, mounted on its own tubular stand, takes instruments or packs up to 22 inches long, as well as dressings, utensils, rubber gloves and solutions. It generates and then stores steam under pressure in its outer chamber for instant use. No water or waste connections are needed. Automatically controlled, its simple, fast operation makes it ideal for clinics and as stand-by equipment for hospitals. Of sturdy bronze, brass and copper construction throughout, it's built for long, steady use. $1,150 at Detroit.



LV-2 • 12" x 22" Chamber



HP-2 • 8" x 16" Chamber

Pelton also provides the HP-2 (8 by 16-inch chamber). $450 at Detroit.

PROVED PERFORMANCE

For many years Pelton autoclaves have been recognized as the finest available. More are in use in America than any other self-contained autoclave.

See the Peltons at your dealer's or mail coupon for literature

THE PELTON & CRANE COMPANY
632 HARPER AVE., DETROIT 2, MICH.
Please send me literature on your self-contained autoclaves, LV-2 and HP-2.

Name_____

Hospital_____

Address_____

City
State_____

PELTON

Professional Equipment since 1900

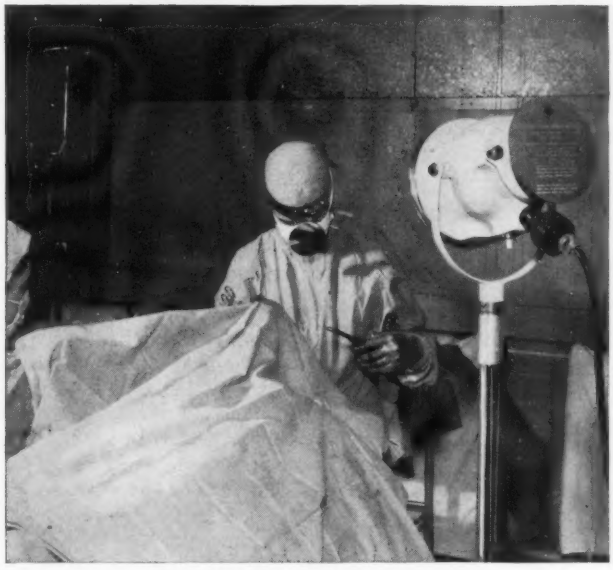
Ether Blast Kills Boy Awaiting Tonsil Operation
One of a family of 10 children
rday in Southside Hos-
after an anesthetic
tricity, was described by hospital
officials as a "once in a lifetime
accident."
investigation of why the
sion, first in the hospital's
originated in a tank

This headline from an Eastern newspaper dramatizes the need for safety in Minor as well as Major Surgeries.

THINK TWICE!

. . *think about* **EXPLOSION-PROOF SAFETY**

. . *think about* **QUALITY ILLUMINATION**



▶ This explosion-proof light brings lighting safety to all surgery in which head mirror is (or should be) used.

CASTLE'S no. 56 REFLEX IS THE ANSWER

(Head-Mirror Light)

- ▶ How many times has the surgeon discarded the head-mirror for lack of a safe, adequate light source?
- ▶ Now, where explosive gases are used, the new Reflex Light eliminates dangerous electrical components of ordinary head-mirror lamps.
- ▶ The Reflex provides better vision . . . with light intensities three times that of ordinary fixtures.
- ▶ Saves personnel time in constant readjustment of old type concentrated "spots" . . . projects a 70° cone of light, so wide the surgeon moves with perfect freedom, yet has constant focus of high-intensity mirrored light.
- ▶ Universal positioning . . . lamphead rotates 360° in both horizontal and vertical planes . . . automatic spring-lock upright gives hi-lo adjustment 35-48″ from floor. No manual locks.

Castle LIGHTS and STERILIZERS

WRITE for detailed specifications

_____

_____

WILMOT CASTLE COMPANY
1803 E. Henrietta Rd. Rochester, N. Y.

Linde Air Products Names Two Vice Presidents

Eugene Easterly has been appointed Vice-President—Distribution, and E. G. Hickling, Vice-President—Operations, Linde Air Products Co., a division of Union Carbide and Carbon Corporation.

Mr. Easterly joined Linde as a development engineer in 1931. Mr. Hickling began his career with Linde in 1927 as an engineer at the company's laboratory in Buffalo.

New Division Director for Colson

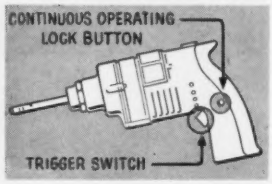
Saul R. Gilford has been named director of the medical instrument division of the Colson Corporation, Elyria, Ohio. The division recently was established to produce a line of electronic hospital instruments which include an automatic blood pressure recorder and a device used in the measurement of the flow of blood from the heart.

Mr. Gilford had been at the National Bureau of Standards since 1948 as an electronic scientist. He is on the administrative committee of the Institute of Radio Engineers and a member of the committee on Electronic Techniques in Medicine and Biology.

. . . only the SUPER SAFE

ORTHOPEDIC *Electric* CAST CUTTER

offers a 6-MONTHS GUARANTEE ON MOTOR UNIT!



At last! Here's a non-rotating saw for cutting and removing *all* types of plaster casts, including the new, tough plastics!

- **Oscillating blade can safely touch the skin without injury to patient or operator.**
- **Pistol-grip design, and direct drive from motor to blade, gives operator positive control and ease of maneuvering.**
- **Ruggedly built for long, trouble-free service. Motor can be run for lengthy periods without overheating, and is guaranteed for a 6-months period.**
- **Has trigger switch and continuous operation lock button, allowing one hand manipulation.**

No. 399
ORTHOPEDIC ELECTRIC CAST CUTTER

. . . complete with 4 stainless steel circular blades (two 1¾" dia. and two 2½" dia.) and 2 wrenches for changing blades . . .

$84.00

•

Available through your surgical supply dealer.

OEC *Orthopedic* EQUIPMENT CO.
BOURBON, INDIANA
SPLINTS • FRACTURE EQUIPMENT • SMo INTERNAL BONE APPLIANCES • BONE INSTRUMENTS

Bon Voyage Party Given Ethicon Representative

Before Lou Pacelli (center), West Coast representative of Ethicon, Inc., departed on a European trip, he was guest of honor at a party at the Palo Alto, Calif., home of Bill Little, western representative for Becton, Dickinson and Co. Shown with Pacelli are James Halin (l.), senior purchasing agent, University of California Medical Center, San Francisco, and John Konce, branch manager, American Hospital Supply, San Francisco.

Leitz Introduces Micro-Manipulator

A new micro-manipulator with single one-hand mechanical control, has been introduced by E. Leitz, Inc. It is so precise that micro-knives, needles and pipettes can be kept with a 0.136 mm field of view during operations on living cells. The instrument has been developed for use in the biological sciences and technology.

Carolina Cotton Appoints New Sales Representative

John Smith has been appointed sales representative for Carolina Absorbent Cotton Company in Texas and Louisiana. Before joining Carolina he was associated with Miles Laboratories and contacted wholesale and retail drug accounts in Louisiana and east Texas.

Fougera Elects Two Officers

Directors of E. Fougera & Co., Inc. have elected Clifford H. Bradney vice-president, Robert M. Post secretary.

Mr. Bradney is executive assistant to the president, in charge of sales and advertising, and will continue to have these responsibilities. Mr. Post has been legal counsel to the board of directors.

tested in use...

Metzenbaum

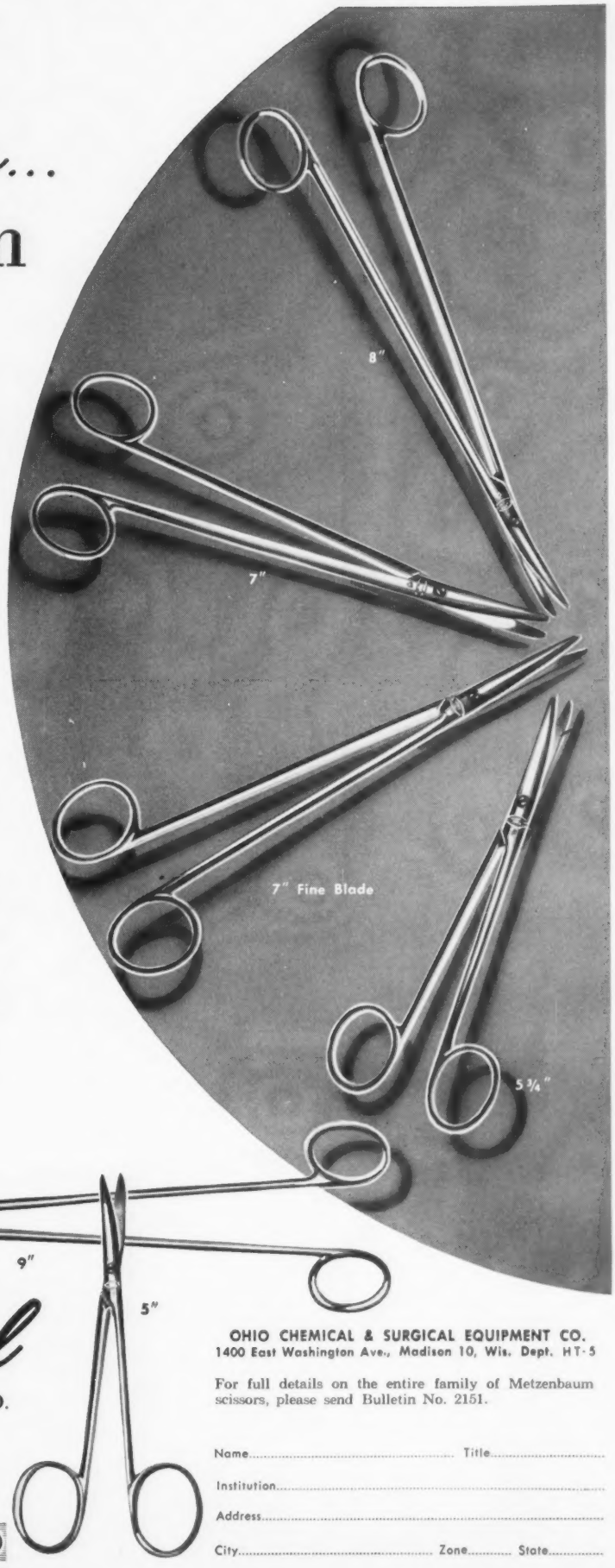
SURGICAL SCISSORS

by

STILLE SWEDEN

Metzenbaum scissors have met the test of actual use by many of the most discriminating surgeons throughout the world — many have been used ten to fifteen years without need for resharpening or repair. Where precision and quality are demanded, these scissors give the outstanding service found only in instruments made of tempered Stille Swedish stainless steel.

Stille craftsmen have perfected the art of creating flawless surgical instruments. Each is designed for the utmost in strength and durability and "feel" — all so important to the surgeon. They bear the trade-mark synonymous with quality for over a century — Stille.



OHIO

Ohio Chemical

OHIO CHEMICAL & SURGICAL EQUIPMENT CO.
MADISON 10, WISCONSIN

Distributed in U.S.A. exclusively by
OHIO CHEMICAL & SURGICAL EQUIPMENT CO.
Madison 10, Wisconsin
OHIO CHEMICAL PACIFIC COMPANY
San Francisco 3, Calif.
(Divisions of Air Reduction Company, Incorporated)

AN AIR REDUCTION PRODUCT

OHIO CHEMICAL & SURGICAL EQUIPMENT CO.
1400 East Washington Ave., Madison 10, Wis. Dept. HT-5

For full details on the entire family of Metzenbaum scissors, please send Bulletin No. 2151.

Name..... Title.....

Institution.....

Address.....

City..... Zone..... State.....

antibiotics

Stress SF Fortified

with vitamins

Terramycin - SF

Brand of oxytetracycline with vitamins

CAPSULES 250 mg.

Tetracyn - SF

Brand of tetracycline with vitamins

CAPSULES 250 mg. ORAL SUSPENSION (fruit flavored) 125 mg./5 cc. teaspoonful

Pen - SF

Brand of penicillin G potassium with vitamins

CAPSULES 200,000 units

a new pharmaceutical achievement from Pfizer

to fight infection ... Terramycin-SF, Tetracyn-SF and Pen-SF each combines in a single preparation:

1) a potent antibiotic of choice for the treatment of susceptible infections,

2) the Stress Formula vitamins† as proposed by the National Research Council[1] for physiologic support against the stress of infection.

to mobilize the patient's resources for recovery ... B-complex, C and K are vitamins involved in body defense mechanisms and in tissue repair and are required in increased amounts during the stress of infectious disease. By meeting these increased needs, Stress Fortified Terramycin-SF, Tetracyn-SF and Pen-SF contribute markedly to more rapid control of infection and faster convalescence.

to promote a smoother and more rapid convalescence ... "The duration of most acute infectious diseases has been markedly decreased by the use of the various antibiotics," the National Research Council notes. "Nevertheless, *the length of convalescence is to a large measure still dependent on nutritional therapy.*"[1]

with outstanding economy and convenience ... Stress Fortified antibiotic preparations cost little more than the antibiotics alone and offer the convenience of a single preparation replacing two prescriptions.

†The minimum daily dose of each antibiotic *(1Gm. of Terramycin or Tetracyn, or 600,000 units of penicillin)* also supplies the stress vitamin formula *(of the water-soluble vitamins and vitamin K)* recommended by the National Research Council:

Ascorbic acid, U.S.P.	300 mg.	Calcium pantothenate	20 mg.
Thiamine mononitrate	10 mg.	Vitamin B_{12} activity	5 mcg.
Riboflavin	10 mg.	Folic acid	1.5 mg.
Niacinamide	100 mg.	Menadione (vitamin K analog)	2 mg.
Pyridoxine hydrochloride	2 mg.		

1. Pollack, H., and Halpern, B. L.: Therapeutic Nutrition. Prepared with Collaboration of the Committee on Therapeutic Nutrition, Food and Nutrition Board, National Research Council, Baltimore, Waverly Press, 1952.

*Trademark

PFIZER LABORATORIES, Brooklyn 6, N. Y.
Division, Chas. Pfizer & Co., Inc.

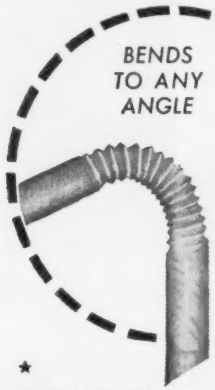
The Only
FLEXIBLE DRINKING TUBE for HOSPITAL USE
PAPER BASED—DISPOSABLE

FLEX-STRAW®

INITIAL COST THE ONLY COST

NO STERILIZING

NO BREAKAGE



★
FOR USE IN BOTH HOT AND COLD LIQUIDS

WHOLESALE PRICES TO HOSPITALS

Regular (Unwrapped)

1M	$5.00 per M
5M	4.75 " "
10M (1 case)	4.50 " "
4 cases or over	3.95 " "

Individually Wrapped

1M	6.00 " "
5M	5.70 " "
10M (1 case)	5.40 " "
4 cases or over	4.75 " "

Canadian Distributors
INGRAM & BELL Ltd.
TORONTO
MONTREAL • WINNIPEG
CALGARY • VANCOUVER
(Prices Higher in Canada)

FLEX-STRAW CO.
2040 Broadway
Santa Monica, Cal.

(continued from page 61)

American Society of Clinical Pathologists.

Speakers and their subjects were: Sister Mary Emerita, O.S.F., St. Gabriel's Hospital, Little Falls, Minn., chairman, medical technology committee, Catholic Hospital Association, "Blood Bank Records"; Charles E. Berry, associate director, School of Hospital Administration, St. Louis University, and secretary, council on hospital administration, Catholic Hospital Association, "Legal Aspects of Blood Banking."

William Harrington, M.D., Washington University School of Medicine, St. Louis, "Antigens and Antibiotics of Human Blood Groups," "The Rh System," "Blood Groups and Disease," and "Blood and Plasma Transfusion Hazards"; Virgil Loeb, Jr., Washington University School of Medicine, "A Brief History of Blood Banking," "Blood Donor Hazards," and "Anti-Globulin Tests"; Sister Ann Marie, R.S.M., St. John's Hospital, St. Louis, "Blood Grouping Technics"; and Sister Martin Mary, S.S.M., St. Mary's Hospital, St. Louis, "Cross-Matching Technics."

Helen Madden, M.T. (ASCP), Blood Grouping Laboratories, Boston, explained the Coombs test technics and discussed "Indication for and Technics of Antibody Titrations."

Radiologists Hold Fifth Inter-American Congress

A three day meeting of the Inter-American Congress of Radiology was held in the Shoreham Hotel, Washington, D. C., from April 24 to 29.

Refresher courses in the latest application of x-ray, radium and radioactive substances in diagnosis and treatment were presented each day for all radiologists, radiation physicists, radiobiologists and other scientists interested in radiology attending the meeting.

Symposiums were held on a variety of subjects, including "New Trends in Cancer Research", "Etiology of Lung Carcinoma", "High Voltage Radiology", "Viruses and Tumor Inhibition", etc.

Representatives from the United States and Latin America attended the meeting.

So far so good...

but will she make it?

High heels and leather soles offer scant protection against skidding on your high-gloss floors. That's why you need LEGGE *Safety* Floor Polishes.

LEGGE Polishes bring out the *true* lustre of your flooring *without* slipperiness. Their co-efficient of friction goes up to *75%* beyond U. L. requirements. And the Safety *lasts*. Slip-meter readings taken 4 months after application show no appreciable loss in slip-resistance. Hospitals, industrial plants and office buildings throughout the country report reductions of *98%* and *more* in slip-accidents.

How much does it cost?

Stacks of case histories testify that LEGGE Maintenance saves up to *33⅓%* on labor and materials. Each polishing lasts far longer. And the costly process of stripping your floors is rarely necessary. For Safety, appearance *and* economy, clip this coupon today.

YOU'RE SAFE WHEN YOU HAVE LEGGE TO STAND ON
LEGGE SYSTEM of Safety Floor Maintenance

Walter G. Legge Company, Inc.
Dept. HT5, 101 Park Ave., New York 17
Branch offices in principal cities.

☐ Have a LEGGE Safety Engineer call to discuss my floors. No obligation.
☐ Send a Free copy of your booklet: "Mr. Higby and the Gremlin"

Name_____
Firm_____
Street_____
City_____ Zone____ State____

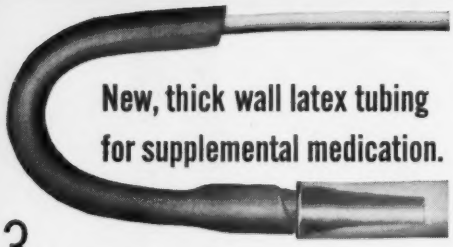
FOUR IMPORTANT reasons to switch to the ALL NEW CUTTER "STREAMLINER" I. V. SAFTISET*

1

New streamlined dripmeter fits the hand; has new, smaller insertion tip.

New, single-wire "Bend-the-Blue" Safticlamp. New, smaller plastic tubing, too.

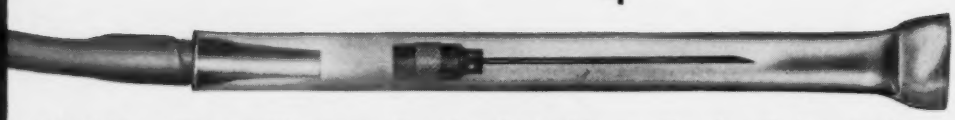
2



New, thick wall latex tubing for supplemental medication.

3

4



Available with or without needle. Needle inside plastic sheath is actually detached from adapter—allowing complete sterilization of all surfaces. Needle may be replaced aseptically should different size be desired.

*TM

Simplify for safety with the "STREAMLINER"

CUTTER

CUTTER Laboratories
BERKELEY, CALIFORNIA

the **OR**

A monthly meeting place for the official
ASSOCIATIONS OF OPERATING ROOM NURSES

a section of special interest to

Operating Room Supervisors, Surgeons, and Nurses *Sponsored by* **ETHICON, Inc.**

contributions are welcome

Fresno A.O.R.N. Holds Organizational Meeting

The first official meeting of the Fresno (Calif.) Association of Operating Room Nurses was held a few months ago. Pictured at left are the officers of the new group. Front row, (l. to r.): Miss Mary Sands, Chairman, Fresno Community Hospital; Miss Amanda Laterza, Vice Chairman and Program Chairman, VA hospital; Mrs. Helen Woodward, Secretary and Treasurer, VA hospital. Back row (l. to r.): Miss Ruth Johnson, Chairman of Nominations Committee, Fresno County General Hospital; Mrs. Eula Bryant, Chairman of Membership Committee, Valley Children's Hospital; Mrs. Hazel Lawler, Chairman of Rules and Regulations, Madera County Hospital; Mr. William Manolio, Publicity Chairman, VA hospital.

Pictured above are some of the other members of the Fresno group present at the meeting.

Body Temperature Studies in Anesthetized Man

Effect of Environmental Temperature, Humidity, and Anesthesia System

By Robert E. Clark, M.D., Louis R. Orkin, M.D.
and E. A. Rovenstine, M.D., New York City*

• *The following article is reprinted by permission of the authors and the* Journal of the American Medical Association, *where it appeared January 23, 1954.*

The possibility of great harm occurring as a sequel to marked elevations of body temperature is well known. Heat retention (also called heat stroke or heat pyrexia) may be associated with convulsions, coma, and psychic disturbances in the recovery phase.[1] In fatal cases, generalized degeneration of the neurons of the central nervous system, centrolobular liver necrosis, lower nephron nephrosis, and widespread hemorrhages, especially in the lungs and subendocardial tissues, are found.[2] The similarity of the pathological lesions found in patients dying following fever therapy and those produced by anoxia from any cause has been stressed by Hartman[3]; hypoxia occurs at the tissue level because of increased metabolic oxygen demand associated with fever, which cannot be met by the cardiorespiratory transport system.

It has been suggested that liver cells in addition to the cells of the central nervous system are particularly susceptible to damage during high fever.[4] Jaundice is a well-recognized complication of fever therapy, and several deaths have occurred following such treatment in which extensive liver necrosis was found at autopsy. Lesser elevations of fever produce apparently reversible impairment of liver function.

In addition, hyperthermia imposes a severe stress on the cardiovascular system. Heating the entire skin area may lower the over-all peripheral resistance to two-thirds or half of normal, according to Bazett.[5] In order for an effective general circulation to be maintained, the cardiac output increases and splanchnic vasoconstriction occurs.[6] These cardiovascular responses to heat decrease the ability of the body to withstand further circulatory stress. Experimentally, exposure to a hot environment sufficient to cause a rise in body temperature decreases the ability of animals to survive hemorrhagic shock,[7] traumatic shock,[8] and shock secondary to thermal burns.[9] External thermal stress adversely affects the circulatory status of patients in congestive heart failure, as has been shown by Berenson and Burch; in normal subjects circulatory responses to positional change are impaired.

This clinic has been particularly aware of the serious nature of the problem of heat disorders during anesthesia for many years because of high temperatures and humidity in the operating rooms during several months of the year. Despite vigilance, in the past two years alone two children and one adult have had convulsions associated with hyperpyrexia while anesthetized. Certain similarities were notable in all of these cases. All occurred during the summer months, with the temperature of the operating room near 90 F and the relative humidity high. All three patients were acutely ill, having had peritonitis for 36 hours or longer before surgical intervention. The cause of the peritonitis was a perforated appendix in two cases, and was due to leakage from the duodenal stump following subtotal gastrectomy in the third. In every case, convulsions were preceded by a rapid, progressive rise in body temperature. Fortunately, prompt treatment directed toward controlling the convulsions, rapidly reducing the fever, and providing maximal oxygenation averted a fatal outcome in each instance.

The dangers of hyperthemia following anesthesia in children have recently been emphasized by Bigler and McQuiston.[10] Two deaths in infants attributable

*From the Department of Anesthesiology, New York University-Postgraduate Medical School and the Division of Anesthesia, Bellevue Hospital.

Dr. Clark is now at the State University of New York College of Medicine, Brooklyn.

Read before the Section on Anesthesiology at the 102nd Annual Meeting of the American Medical Association, New York, June 2, 1953.

1. Ferris, E. B.; Blankenhorn, M.A.; Robinson, H. W., and Cullen, G. E.: Heat Stroke: Clinical and Chemical Observations on 44 Cases. *J. Clin. Invest.* 17:249, 1938.

2. Malamud, N.; Haymaker, W., and Custer, R. P.: Heat Stroke; a Clinico-Pathologic Study of 125 Fatal Cases. *Mil. Surgeon* 99:397, 1946.

3. Hartman, F. W.: Lesions of Brain Following Fever Therapy. *J.A.M.A.* 109:2116 (Dec. 25) 1937.

4. Bragdon, J. H.: The Hepatitis of Hyperthermia: Report of a Fatal Case. *New England J. Med.* 237:765, 1947.

5. Bazett, H. C.: Effect of Heat on the Blood Volume and Circulation. *J.A.M.A.* 111:1841 (Nov. 12) 1938.

6. Daily, W. M., and Harrison, T. R.: Study of the Mechanism and Treatment of Experimental Heat Pyrexia. *Am. J. M. Sc.* 215:42, 1948.

7. Blalock, A., and Mason, M. F.: Comparison of Effects of Heat and Those of Cold in Prevention and Treatment of Shock. *Arch. Surg.* 42:1054 (June) 1941.

8. Ricca, R. A.; Fink, F.; Katzin, L. I., and Warren, S. L.: Effect of Environmental Temperature on Experimental Traumatic Shock in Dogs. *J. Clin. Invest.* 24:127, 1945.

9. Elman, R.; Cox, W.; Lischer, C., and Mueller, A. J.: Mortality in Severe Experimental Burns as Affected by Environmental Temperature. *Proc. Soc. Exper. Biol. & Med.* 51:350, 1942.

10. Bigler, J. A., and McQuiston, W. O.: Body Temperature During Anesthesia in Infants and Children. *J.A.M.A.* 146:551 (June 9) 1951.

to this cause were reported. Knight[11] observed rises as high as 5 to 7 degrees F in body temperature following operations performed in the summer. These temperature rises appeared to be associated with elevated room temperature, prolonged surgery, heavy draping, and the use of the carbon dioxide absorption system. Burstein and Mark,[12] as well as Knight, have advocated cooling the inspired gases when to-and-fro or circle absorption systems are used in hot weather. The observations of rectal temperature during anesthesia made by Searles and Lenahan[13] show in a general way the effects of environmental conditions on body temperature.

TABLE 1.—*Age and Sex Distribution, Anesthetic Agents Used, and Duration of Anesthesia in Heat Study Cases*

	Type of Anesthesia System			
	To-and-Fro	Circle	Non-Rebreathing	Total
No. of Cases	67	54	43	164
Ratio of Males:Females	39:28	32:22	29:14	100:64
Age, Yr.				
12-20	4	..	7	11
21-40	10	13	9	32
41-60	26	20	9	55
61-70	21	14	11	46
Over 70	6	7	7	20
Anesthetic Agent				
Cyclopropane	58	41	..	..
Ether	9	13	..	..
Nitrous oxide-oxygen-thiopental	..	..	39	..
Nitrous oxide-oxygen-trichlorethylene	..	..	3	..
Nitrous oxide-oxygen-ether	..	..	1	..
Duration of Anesthesia				
Mean	3 hr. 57 min.	4 hr. 8 min.	4 hr. 34 min.	4 hr. 13 min.

No systematic study has been made to show the behavior of body temperature in the anesthetized subject under various conditions of room temperature and humidity. It would be desirable to know the critical temperature and humidity conditions above which heat retention becomes a frequent complication. Moreover, no clear relationship has been demonstrated between body temperature changes and choice of anesthesia system. The present study was undertaken to provide more definite information about these matters that might be of value to the anesthesiologist and surgeon.

CLINICAL MATERIAL AND METHODS

Temperature measurements were made in 212 general hospital patients undergoing surgery and general anesthesia. The records of 164 of these patients were selected for a study relating body temperature changes with environmental temperature, humidity, and choice of anesthesia system. The criteria used in selecting these cases were as follows: Only cases in which surgical procedures lasted more than two hours were used. The subjects were patients weighing more than 90 lb. (40.9 kg.) who had no fever before operation and who showed no evidence of shock during the procedure.

The duration of anesthesia varied from two to nine and one-half hours; the average for all cases was slightly over four hours. The age of the subjects ranged from 13 to 85 years. Age and sex distribution are presented in table 1.

Small children were excluded because their smaller body mass and different physiological responses to heat render them unsuitable for comparison with adult subjects. Patients with fever were excluded from the study because it was assumed that they might differ from afebrile subjects in their responses to thermal stress. Rectal temperature was used as a measure of internal body temperature in 150 cases; gastric temperature was used in 9 cases; and low esophageal temperature was used in 5 cases. The mean body temperature for all subjects at the beginning of anesthesia was 99.2 F. The variation was from 97.0 to 100.8 F; however, less than 4% of cases fell outside of the range 98.0 to 100.2 F.

Patients in whom signs of hemorrhagic or traumatic shock developed during the course of the operation were not included in the study. Body temperature was regularly observed to fall after the onset of shock in these cases, and their inclusion was not considered permissible.

All patients except six received preanesthetic medication within 90 minutes of induction of anesthesia. Of these, all received a therapeutic dose of a belladonna drug, which in over 93% of cases consisted of 0.4 mg. of atropine. Meperidine was given to 52% of the patients in addition, and 35% received morphine.

Inhalation anesthesia, administered by endotracheal technique, was used in all cases. Three different anesthesia systems were used: to-and-fro absorption, circle absorption, and non-rebreathing technique. The first two mentioned were employed in a closed system in all cases in this series. The Stephen-Slater valve,[14] which permits no rebreathing of exhaled gases, was used in the third group.

The anesthetic agent employed with the to-and-fro and circle systems was either cyclopropane or diethyl ether. Cyclopropane was used approximately four times more frequently than ether, with both the to-and-fro and the circle systems. More than 90% of the patients anesthetized with the non-rebreathing technique received nitrous oxide and oxygen supplemented with sodium thiopental. In the remaining cases either trichlorethylene or ether was the supplement (table 1). Flows of 6 to 12 liters per minute of nitrous oxide-oxygen were required; concentrations of nitrous oxide above 75% were not employed.

This study was conducted during the course of one calendar year. Thus it was possible to assess the responses of anesthetized patients to a graded series of thermal stresses related to seasonal changes. The operating suite in which the study was made is not air-conditioned. Instruments are sterilized by boiling in a room that opens directly upon two adjacent operating rooms. This arrangement results in considerable humidification of the room air. The overhead operating lights in use utilize four 250 watt incandescent lamps. The sterile draping system in practice in this hospital was used consistently throughout the study: four small doubled sheets ("clinics") were placed on the four sides of the field; one sheet, folded in half, was then placed respectively across the foot and one across the head of the table; finally, a laparotomy sheet was placed on top of these drapes.

The wet and dry bulb temperature of the room air was measured to within 0.5 degrees F with a sling

(Continued on next page)

11. Knight, R. T.: Elevation of Body Temperature During Anesthesia and Its Control. *Anesth. & Analg.* 21:117, 1942.

12. Burstein, C. L., and Mark, L. C.: Control of Temperature of the Inspired Atmosphere and Absorption Technique. *Anesthesiology* 9:197, 1948.

13. Searles, P. W., and Lenahan, R. M.: Changes in Skin and Rectal Temperature During Surgical Anesthesia. *New York J. Med.* 52:1896, 1952.

14. Stephen, C. R., and Slater, H. M.: Nonresisting Non-rebreathing Valve. *Anesthesiology* 9:550, 1948.

psychrometer. Measurements were made at approximately 90 minute intervals during the procedure. The relative humidity was computed from psychometric tables.

Body temperature, and temperature within the anesthesia system and the airway, was measured with a Micromax 6 point recording thermocouple (manufactured by the Leeds and Northrup Co., Philadelphia). Copper and constantan wire thermocouples were used. The accuracy of this machine is ± 0.3 degrees F. A United States Bureau of Standards calibrated mercury thermometer was used to check the performance of the machine, and during many of the measurements, one thermocouple was kept in an ice bath as a reference point. The latter was desirable, although not essential, inasmuch as the machine utilizes a self-contained, known electromotive force instead of a cold junction as a basis for comparison with the electromotive force produced by the test thermocouple.

Temperature was recorded between points at one minute intervals; hence, the time between successive readings on any one thermocouple was six minutes. The rectal thermocouple, mounted in a plastic rod, was inserted 4 or more inches into the rectum at the earliest possible moment after anesthesia was established. Gastric or esophageal temperatures were obtained with a thermocouple mounted in a length of vinyl plastic tubing (2.5 mm. external diameter), which had been stiffened by treatment with heat. Fine, unsheathed, insulated thermocouple wires were used to obtain temperatures in the airway and in anesthesia equipment. Low tracheal or carinal temperature was obtained by inserting such a wire a measured distance beyond the tip of the endotracheal airway, usually 3 to 4 cm. Temperature in the to-and-fro cannister was measured in the proximal one-third of the cannister. Measurements were made at several locations in the circle cannister, through holes drilled in the sides; only measurements made in the proximal one-third are described herein. Temperatures were measured in the accordion tubes of the circle machine. Two thermocouples were placed in the inspiratory tube, one 4 in. from the Y piece and the other adjacent to the machine; two other thermocouples were similarly placed in the expiratory tube. The accordion tubes used were 31 in. (77.5 cm.) long. The temperature under the drapes adjoining the chest, the flank, the hip, and between the thighs was measured. Thermocouples were placed about 3 cm. from the body and were protected from moisture.

The mean temperature was computed from a series of observations in a number of patients, six minutes apart over a period of two or more hours. Two to-and-fro, or two circle cannisters were alternated at hourly intervals, and were not cooled. Data upon which mean cannister temperature was based were only those observed when the patient was breathing through the test cannister, not during the cooling period of the cannister.

RESULTS

The effects of room temperature, humidity, and anesthesia system on body temperature were analyzed in the following way. Body temperature change, whether a rise or a fall from the initial recorded internal temperature, was plotted against the duration of anesthesia in hours. The body temperature records were then grouped in two general ways, according to environmental conditions: first, by the dry-bulb temperature of the operating room (in 5 degree F ranges), and each range divided in two subgroups according to whether the relative humidity was above or below an arbitrary figure of 55%; second, solely by the wet-bulb temperature of the room. The distribution of patients by these two methods is shown in tables 2 and 3 respectively.

TABLE 2.—*Distribution of Heat Study Cases According to Dry-Bulb Temperature Range (F), Relative Humidity, and Anesthesia System*

Relative Humidity	Type of Anesthesia System: To-and-Fro	Circle	Non-Rebreathing	
Below 55%				
75-79.5	6	12	4	
80-84.5	18	21	17	
85-89.5	12	7	8	
90-95	7	3	3	
Above 55%				
80-84.5	5	5	5	
85-89.5	16	6	3	
90-95	3	..	3	
Totals	67	54	43	Grand Total 164

TABLE 3.—*Distribution of Heat Study Cases According to Wet-Bulb Temperature Range and Anesthesia System*

Wet-Bulb Temperature, F	Type of Anesthesia System: To-and-Fro	Circle	Non-Rebreathing	
58-64.5	8	17	11	
65-69.5	15	19	11	
70-74.5	19	8	11	
75-82	25	10	10	
Totals	67	54	43	Grand Total 164

Figures 1 and 2 show the manner in which the data for each temperature range were plotted; some 30 other charts cannot be shown because of limitations of space. Each dot on the scatter chart represents the body temperature of one patient at the time shown; the average temperature change is shown by a curve. Temperature measurements were actually made at 6 minute intervals; however, in the interests of clarity, the interval shown on the charts is 18 minutes.

One fact immediately apparent is the wide variability of rate and degree of body temperature rise

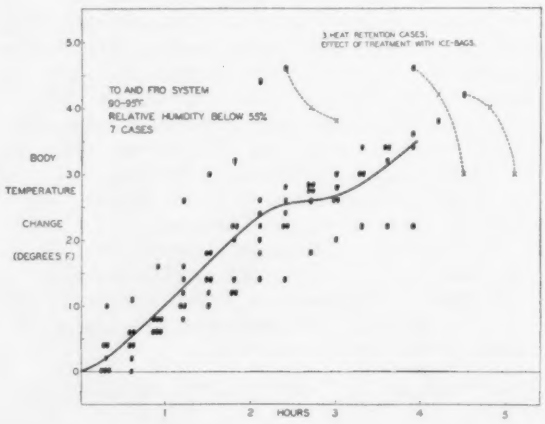


Fig. 1.—Body temperature changes during anesthesia in seven cases with the temperature of the operating room ranging from 90 to 95 F.

shown by different patients. The slope of the temperature curve for any particular patient is apt to be bumpy and irregular, apparently related to the variable degree and intermittent character of sweating seen in these subjects. A definite trend in the course of the body temperature is usually discernible however.

In figure 1, at a dry-bulb temperature of 90 to 95 F with the relative humidity below 55%, three out of seven patients anesthetized with the to-and-fro system had heat retention requiring therapy with ice-bags. This occurred after 2.5 hours, 4 hours, and 4.5 hours of anesthesia. Significantly, the average wet-bulb temperature for the seven cases was 76.5 F. Only part of the cooling curve of the treated patients is shown; however, the effectiveness of therapy can be clearly seen.

At 80 to 84.5 F, with the relative humidity above 55%, two of five patients anesthetized with the to-and-fro system were on the verge of heat retention after 3.5 hours (not shown). The average wet-bulb temperature was 74 F. Heat retention was averted in one patient by the application of ice-bags, and in the other when severe hemorrhagic shock supervened.

Heat retention occurred in 3 out of 16 patients in whom to-and-fro absorption was used at 85 to 89.5 F, with the relative humidity above 55% (fig. 2). The average body temperature rise for the group as a whole was over 4 degrees F in five hours. The average wet-bulb temperature was 77.5 F.

At 90 to 95 F with the relative humidity above 55%, the body temperature rose at a rate of over 1 degree F per hour in three patients anesthetized with the to-and-fro system (not shown). The average wet-bulb temperature was 81 F. Heat retention developed in only one patient, but in both of the other two it was imminent at the time surgery was terminated. Under comparable conditions, heat retention developed in only one patient anesthetized with the circle or non-rebreathing system.

The average body temperature curves for the data grouped by dry-bulb temperature range, with the relative humidity below and above 55%, are summarized in figures 3 and 4.

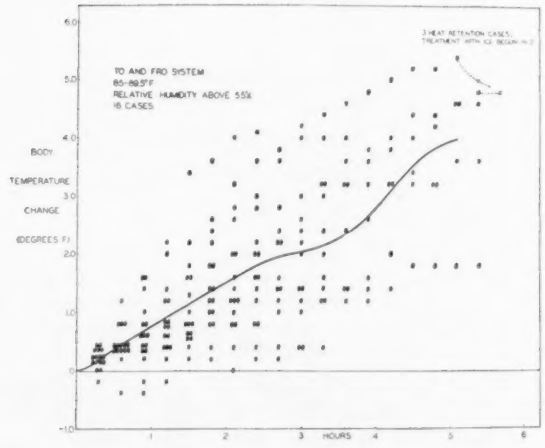


Fig. 2.—Body temperature changes during anesthesia in 16 cases with the temperature of the operating room ranging from 85 to 89.5 F.

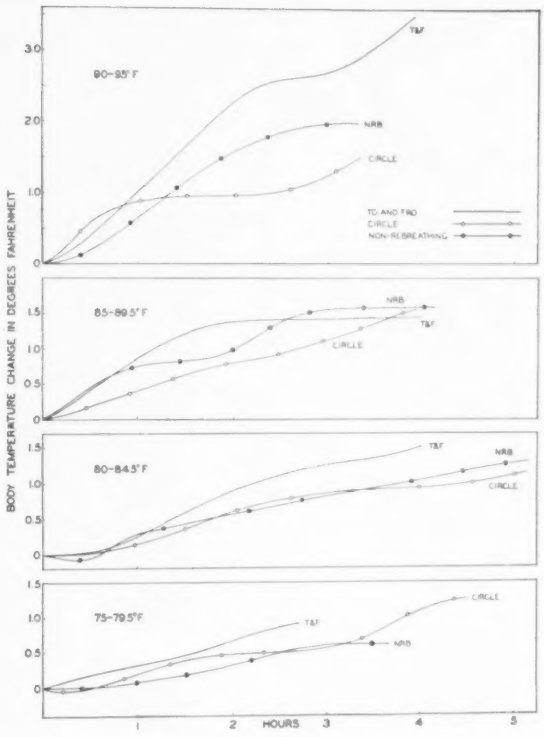


Fig. 3.—Average body temperature curves during anesthesia with the operating room temperature at various ranges but the relative humidity always below 55%.

Average body temperature curves plotted solely in relation to the wet-bulb temperature are shown in figure 5. From the statistical standpoint and for reasons that will be discussed, this figure is the one best suited for comparing the heating effects of the three anesthesia systems.

At wet-bulb temperatures below 75 F, the height and rate of body temperature rise were slightly but consistently greater in patients anesthetized with the to-and-fro system than when the circle and non-rebreathing systems were used. Above 75 F, this effect was considerably more marked. The rate and height of body temperature rise was similar with both the circle and non-rebreathing systems, although it was sometimes slightly higher with the latter.

The results of air temperature measurements under the drapes, adjoining the subject's body, are shown in table 4. The temperature between the interradiating surfaces of the thighs approached body temperature closely; only measurements made adjacent to the chest, flank, and hip are included in the

TABLE 4.—*Average Air Temperature Observed Under Surgical Drapes*

Room Temperature, F	Under Drapes, F	No. of Patients	No. of Measurements
75-79.5	89	22	586
80-84.5	93	30	1,194
85-89.5	96	11	419
90-95	98	13	309

(Continued on next page)

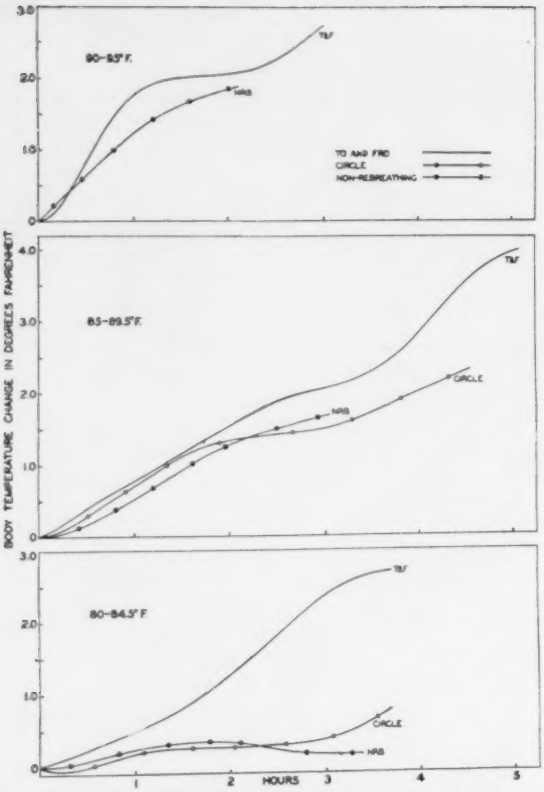


Fig. 4.—Average body temperature curves during anesthesia with the operating room temperature at various ranges but the relative humidity always above 55%.

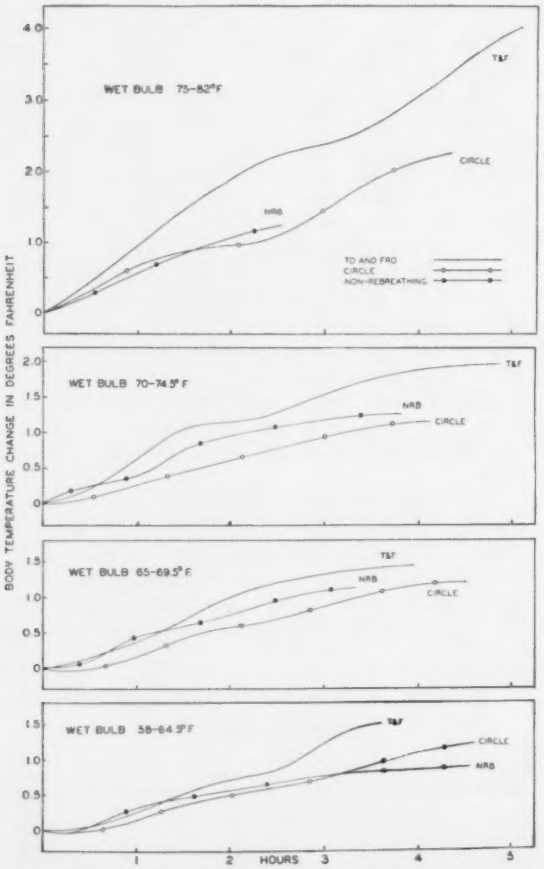


Fig. 5.—Body temperature changes with different anesthesia systems at various wet-bulb temperatures of the operating room.

results shown in the table. The air temperature under the drapes was 8 to 10 degrees warmer than room air when the latter was 80 to 90 F. Above a room temperature of 90 F, the temperature under the drapes approached body temperatures. The results of temperature measurements made in the airway, and in various locations in the three anesthesia systems studied, are shown in tables 5 and 6. Attention is called to the variation in temperature observed. The manner in which average temperature was computed has been described. The average temperature relationships within the three systems are summarized in figure 6.

TABLE 5.—*Average Fahrenheit Temperatures in Various Locations in To-and-Fro, Circle, and Non-Rebreathing Anesthetic Systems*

	Location				
	Bag	Cannister	Adaptor	Mid-Tube	Low Trachea
To-and-Fro System					
No. of measurements ...	175	251	996	488	1,268
No. of cases	7	22	33	13	37
Variation, F	80.0-96.2	80.4-141.8	98.0-122.8	97.4-111.0	98.2-108.0
Mean temperature, F	86.6	116.2	105.8	103.1	101.8
Circle System					
No. of measurements ...	189	57	943	128	1,479
No. of cases	7	3	27	4	41
Variation, F	80.8-96.0	75.2-137.2	86.2-99.8	95.6-100.4	93.6-101.2
Mean temperature, F	86.9	117.5	91.7	97.9	96.9
Non-Rebreathing System					
No. of measurements ...	175	...	604	...	500
No. of cases	5	...	16	...	16
Variation, F	75.0-88.0	...	84.2-94.6	...	90.0-99.4
Mean temperature, F	81.1	...	89.7	...	94.1

TABLE 6.—*Temperature Within the Accordion Tubing in the Circle System*

	Inspiratory Tubing		Expiratory Tubing	
	Adjoining Machine	Adjoining Y Piece	Adjoining Machine	Adjoining Y Piece
No. of measurements	159	159	39	39
No. of cases	6	6	2	2
Mean temperature, F	90.8	89.4	87.0	91.2

COMMENT

Some of the undesirable effects that may result from heat retention have been mentioned. This type of heat disorder arises from a disturbance of the normal balance between heat gain to the body and heat loss.

The principal source of heat gain is internal heat production from the combustion of carbohydrate,

protein, and fat, and to a minor degree from the specific dynamic action of protein. In addition, fever per se increases metabolic heat production by about 7% per degree Fahrenheit. Surgical patients may also gain heat from sources outside the body by radiation and conduction. Examples are the radiant heating effects of the operating lights and the warm bodies of the surgeons on the one hand, and heat gain from warm objects such as repeatedly applied hot laparotomy pads on the other.

For thermal equilibrium to exist, the summation of factors resulting in heat gain must be balanced by an equal loss of heat by the body. The significance of a rising body temperature during anesthesia is a disparity between these two factors. Heat loss is mediated solely by four physical processes: radiation, convection, conduction, and evaporation.

Heat loss by radiation is influenced chiefly by two factors: first, the difference in surface temperature of the subject and the objects surrounding him and, second, the effective radiating surface area. This area is always less than the total body area because of interradiating effects. Radiation is the principal means of body heat loss at comfortable room temperatures. However, its importance decreases rapidly above 89 F, and radiation loss becomes zero when air temperature equals skin temperature.[15]

Conduction is not ordinarily an important means of heat loss. However, when large areas of the body are in contact with solid objects, conduction assumes greater importance. The use of a water-cooled mattress[10] or ice-bags are examples of the effective application of conductive heat loss. The former has the advantage of making use of a large portion of the body area that would not otherwise be available for cooling the body. Under operating room conditions, the methods that we have found most effective in treating pyrexia are those that utilize conduction.

Heat loss by convection is that heat lost by warming of the air that comes in contact with the body. Loss from natural convection is always small; however, forced convection is much more effective. Heat loss by the latter is proportional to the square root of the air velocity.[16] Surgical draping impedes convection. Moreover, the promotion of air currents in operating rooms by fans is not generally approved. As a consequence, forced convection as a means of heat dissipation is frequently unavailable to the surgical patient.

At comfortable room temperature (68 to 70 F), evaporation plays a minor role in body heat elimination; above 88 to 90 F, however, it is the principal means, and above 94 F it is the sole means by which body heat can be lost.[15] It can be seen from table 4 that above a room temperature of 85 F, the temperature under the surgical drapes is 96 F or more. Hence, above this room temperature, it is clear that in any patient in whom the sweating mechanism fails heat retention will almost certainly develop. It is our opinion that the lightest possible draping should be used during hot weather. Asepsis is actually maintained more satisfactorily with a light drape, for the patient is less likely to sweat through and contaminate it.

Water loss through the skin includes that which is transudated as well as that secreted by the sweat

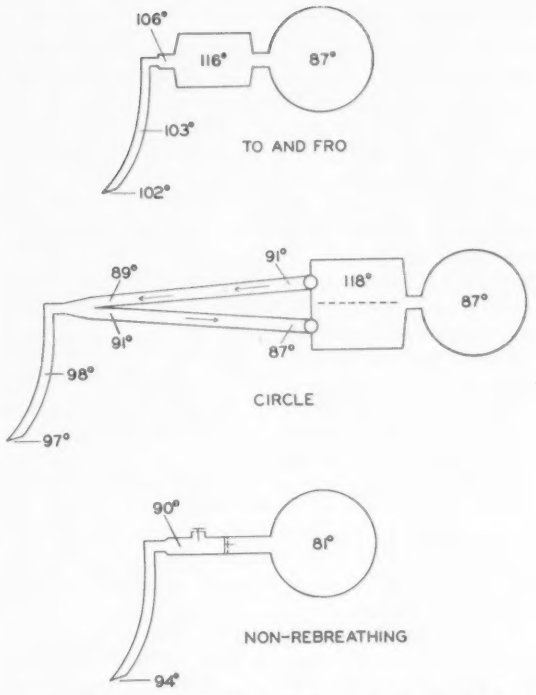


Fig. 6.—Average temperature (Fahrenheit) at various points in the to-and-fro, circle, and non-rebreathing anesthesia systems.

glands. On exposure to heat, the rate of transudation may rise to 50 ml. per square meter per hour or only about 10% of the output of the sweat glands under similar conditions. However, evaporation of transudates assumes importance when the sweating mechanism fails, e.g., heat retention, under conditions in which evaporation is the only means of heat elimination.

Suppression of sweating was uniformly observed before the onset of heat retention in all 10 cases in which it occurred during this study. This has been noted by others.[1] Heat retention was marked not only by the height to which body temperature rose but by its progressive and rapid rise. A rate of temperature rise of 1.2 to 2.0 degrees F per hour was observed at some time during the development of heat retention in all cases.

In some of the patients in whom pyrexia occurred, concomitant measurements of the posterior nasal temperature were made with a mercury clinical thermometer. This temperature was found to provide a very adequate means of detecting and following the course of heat retention. A rectal type thermometer is recommended to avoid the risk of breakage in the nose, and it is advised that the thermometer be inserted at least 2½ in. (6.25 cm.).

The key relationship upon which evaporative heat loss depends is the difference between the vapor pressure of water at skin temperature and the vapor pressure of water in room air. (The latter is equal to the vapor pressure of water at air temperature multiplied by the relative humidity.) When this difference becomes zero at wet-bulb temperatures above 96 F, heat loss by evaporation ceases. A fairly close parallelism exists between wet-bulb temperature and the vapor pressure of water at the wet-bulb temperature. For this reason, the wet-bulb tem-

(Continued on next page)

15. Hardy, J. D.; Milhorat, A. T., and DuBois, E. F.: Basal Metabolism and Heat Loss of Young Women at Temperatures from 22° C. to 35° C. *J. Nutrition* 21:383, 1941.

16. Machle, W., and Hatch, T. F.: Heat; Man's Exchanges and Physiological Responses. *Physiol. Rev.* 27:200, 1947.

perature is the most important factor in determining the upper limits of tolerability of an environment, as has been shown by Eichna and associates.[17]

The dry-bulb temperature taken alone is a poor index of the thermal tolerability of an operating room. A comparison of figures 3 and 4 will make this clear. Both show body temperature changes occurring in relation to similar dry-bulb temperature ranges. However, in figure 4 where the relative humidity is high, the corresponding rate of temperature rise is distinctly steeper than in the other where relative humidity is low.

The relative humidity is misleading and unsatisfactory as a measure of the tolerability of an environment because it bears no absolute relationship to the vapor pressure of water in the air; the relative humidity may be the same at two different dry-bulb temperatures, and the moisture content be very different. Figure 3 illustrates the point; one is led to expect from the three lowest charts that, if the relative humidity is below 55%, evaporative loss will be adequate to prevent marked elevations of body temperature. However, the uppermost chart reveals rises in body temperature higher than some seen in figure 4. The explanation is that, although the relative humidity is below 55% in all the charts in figure 3, the average wet-bulb temperature is 76.5 F in the top chart and only 63 to 70 F in the bottom three.

Figure 5 shows the data replotted in relation to the wet-bulb temperature only. Without respect to system, the trends of body temperature rise follow intimately corresponding rises in wet-bulb temperature. It is to be noted that, above 75 F wet-bulb temperature, body temperature rises rapidly; this effect is marked in patients anesthetized by means of the to-and-fro system, but it also occurs when circle and non-rebreathing systems are used. In 10 patients in whom heat retention occurred, the average wet-bulb temperature ranged from 74 to 82 F; in only one case was the wet-bulb temperature below 75 F.

Evaporation of water from the lung normally dissipates about 10% of the body's heat loss. Warming the respired air to body temperature accounts for an additional 1 or 2%. The fact that this avenue of heat loss is both small and self-limited should be appreciated before any discussion of the effects of anesthesia system on heat economy is undertaken. For example, the non-rebreathing system permits free lung evaporation, yet this factor alone was not enough to prevent a slow rise in body temperature at comfortable room temperatures (fig. 5). This signifies that the summation of factors impeding heat dissipation or resulting in heat gain exceeded the effect of the patient's heat dissipating mechanisms including lung evaporation.

All gases have a very low specific heat; for this reason, only small amounts of heat are involved in heating or cooling large volumes of gas. For example, the heat loss to the body in raising the temperature of 500 liters of gas per hour in the non-rebreathing system from 81 F (fig. 6) to body temperature is 1.5 Cal. per hour. (Calculations: 500 liters times 10 degrees C times 0.0003 Cal. per liter per degree centigrade [specific heat of air] equals 1.5 Cal. per hour.)

17. Eichna, L. W.; Ashe, W. F., Jr.; Bean, W. B., and Shelly, W. B.: The Upper Limits of Environmental Heat and Humidity Tolerated by Acclimatized Men Working in Hot Environments. *J. Indust. Hyg. & Toxicol.* 27:59, 1945.

Much more important as a factor in heat exchange via the lung is evaporation. In the non-rebreathing system, anhydrous gases are inspired, and gases saturated with water vapor at about 90 F are exhaled through the valve. Seventeen grams of water per hour representing 9.8 Cal. per hour heat loss may be vaporized in such a system. (Calculation: 0.034 gm. of water per liter of saturated gas times 500 liters per hour equals 17 gm. of water per hour; 17 gm. times 0.58 Cal. per gram [heat of vaporization] equals 9.8 Cal. per hour.) The total heat loss, 11.3 Cal. per hour in this hypothetical example, represents about 16% of the 71 Cal. per hour basal heat production of an average-sized young man. It should be noted that, of this, over five-sixths is contributed by evaporative loss.

Lesser amounts of water are evaporated from the lung when the circle system is used. This can occur because gases saturated with water vapor are exhaled into the circle system at about 8 degrees F higher temperature than they return saturated to the patient. Gases return saturated because of the water produced by the neutralization reaction between carbon dioxide and soda lime. Condensation occurs in the accordion tube returning gases to the machine, which is at a lower temperature than the exhaled gas. Evaporation by this means is limited and is about 3.3 gm. of water per hour, corresponding to a heat loss of 1.9 Cal. per hour. (Calculation: the number of grams of water in 500 liters of saturated air at 97 F, the temperature of exhaled gases [0.0402 gm. per liter times 500 equals 20.1 gm.], minus the grams of water in 500 liters of saturated air at 89 F, the temperature of delivered gases [0.0335 times 500 equals 16.8 gm.] equals 3.3 gm. of water evaporated per hour. Besides this, 0.7 Cal. per hour is lost by warming gases to body temperature.) The total heat loss by the use of the circle system is about 4% of the basal heat production.

When the to-and-fro system is used, evaporation from the lung cannot occur because the temperature throughout the system is hotter than the exhaled gases (fig. 6). In fact, heat gain to the body results, not principally because of warming by hot gases, but because water condenses within the lung and airway when hot gases saturated with water vapor are cooled to body temperature. If the average temperature of inspired gases is 106 F, and it is assumed that the gas is cooled to body temperature by the time it reaches the alveoli, heat gain to the body through cooling of gases would be 0.6 Cal. per hour. On the other hand, the amount of condensation calculated to occur between lips and lung is 4.3 gm. of water per hour, equivalent to a heat gain of 2.5 Cal. per hour. (0.0532 gm. per liter times 500 liters minus 0.0442 gm. per liter times 500 liters equals 4.3 gm. of water per hour.) The total heat gain represents an increase of about 4% of the basal heat production.

Cole has recently proposed that condensation of water in the respiratory tract constitutes a hazard in the use of carbon dioxide absorption systems. Such condensation does not occur when the circle absorption system is used, as is shown above, but only during the use of the to-and-fro system. The authors do not believe that this condensation per se constitutes any hazard to the patient, but may be disadvantageous only from the standpoint of the resultant heat gain to the body. At comfortable environmental temperatures, patients may be anes-

thetized for many hours by the absorption technique with no harmful effects whatsoever. Under these conditions, alternative avenues of heat dissipation besides evaporation from the lung are available.

On the other hand, under conditions of severe external thermal stress, i.e., wet-bulb temperatures of 75 F or higher, the heat dissipating mechanisms of the body are taxed greatly. Here, the use of the to-and-fro system, which results in a 4% heat gain rather than varying amounts of heat loss afforded by the other systems, is frequently associated with heat retention. In 9 of the 10 cases in this study in which heat retention developed, the to-and-fro system was used.

The quantitative differences in rate of body temperature rise with the three anesthesia systems are best seen in figure 5. This figure is chosen because here body temperature change is shown in relation to wet-bulb temperature, the most valid measure of the thermal stress of an environment. In figures 3 and 4, the issue of system effect is clouded by the vagaries resulting from subdivision according to dry-bulb temperature.

The height and rate of body temperature rise in patients anesthetized with the to-and-fro system were slightly but consistently greater than that seen in cases in which circle or non-rebreathing systems were used. This effect was considerably more marked above 75 F wet-bulb because of the greater number of patients in whom heat retention developed with the to-and-fro system. The reason for these effects seems to be clearly related to the differences in heat exchange via the lung that have already been discussed. Applying ice-bags to the to-and-fro cannister has been shown elsewhere[12] to reduce the air temperature effectually within the system. By this means, it may be possible to reduce the incidence of heat retention with use of the to-and-fro system to a level comparable to that of other inhalation systems.

Not as readily explained is the similarity of body temperature rises seen with the use of the circle and the non-rebreathing system. The non-rebreathing system should permit dissipation of 16% of the basal heat production, as compared with only 4% by the circle system. However, the temperature rise in certain of the charts in figure 5 is slightly higher with the non-rebreathing than with the circle system. No completely satisfactory explanation for this can be offered. It may be significant, however, that all patients anesthetized with the non-rebreathing system breathed spontaneously throughout, and respiration was not assisted. The respiration of most of the patients anesthetized with circle absorption was assisted, and in some, controlled respiration was performed. It is possible that the average respiratory minute-volume in the circle cases may have been greater than that in the non-rebreathing group. Since heat loss from the lung is directly related to the minute-volume, this may provide a partial explanation. In addition, since muscular activity increases heat production, controlled or assisted respiration should be associated with less internal heat production than when respiration is spontaneous.

Mention should be made of the treatment of heat retention in patients undergoing surgery. At the outset, the object of treatment should be clearly defined, i.e., the rapid reduction of the elevated body temperature. This is the paramount consideration, because to permit body temperature to remain markedly elevated is to risk injury to the central nervous system and liver and circulatory collapse. In experimental hyperthermia, the survival rate of animals is directly related to the speed with which the body temperature is lowered to normal limits.[6]

It should be added that it is no simple matter to prevent progression of hyperthermia in an adult of large body mass, and even more difficult to lower his body temperature to normal. The surgical draping not only impedes convection and evaporation but severely limits the body surface area available for cooling therapy. Under these circumstances, evaporative cooling methods, including the vaporization of volatile liquids on the skin, have proved effectual in our hands. As was mentioned previously, under operating room conditions, the most effective methods of treating pyrexia were found to be those that utilized conduction—the water-cooled mattress and ice-bags. In treating a large group of nonsurgical patients with heat retention, Ferris and co-workers[7] also concluded that evaporative methods reduced body temperature too slowly and recommended therapy with ice.

The effectiveness of ice-bags, properly placed and used in sufficient numbers, in promptly relieving dangerous degrees of hyperthermia is clearly shown in figure 1. The preferred locations for placement of ice-bags, insofar as the surgery permits, are between the thighs, the inguinal regions, axillas, flanks, and chest. In adults, eight or more bags, frequently refilled, are often required to reverse the course of a rapidly rising body temperature. Ice-bags, though somewhat inconvenient to use effectively, have the advantage of being generally available in hospitals.

The convenience of the water-cooled mattress when available, and its effectiveness used prophylactically in children is indisputable.[10] Our experience with the mattress has been limited to its use in children, where it has proved very satisfactory. Extension of its use to adults can be recommended. Other effectual contributory methods of treating heat retention include lightening the surgical drape and promoting air currents under the drapes.

Of lesser value in treatment are the use of evaporative methods of cooling, lightening of anesthesia (to lessen depression of the central thermoregulatory center), adequate replacement of water and salt, and changing from the to-and-fro anesthesia system to one that permits dissipation of heat by the lung. These less effectual methods are supplementary and should never be relied on alone to lower marked elevations of temperature.

Heat retention in surgical patients can be prevented. Air conditioning is of course very desirable from this point of view. Where air conditioning is not available, it is advisable to postpone elective surgical procedures when the wet-bulb temperature of the operating room is 75 F or above. The results of this study indicate that above this temperature, body temperature tends to rise substantially during prolonged operations regardless of the anesthesia system. Light surgical draping of the patient is strongly recommended during warm weather. Use of the to-and-fro anesthesia system is best avoided, or if it is used, the cannister should be cooled with ice. Low doses of belladonna premedicant drugs are advisable since they decrease sweating.[18] Patients should be brought to the operating room adequately

(Continued on next page)

18. Frumin, M. J., and Papper, E. M.: Inhibition of Sweating in Man by Scopolamine. *Anesthesiology* 12:627, 1951.

DIACK

SINCE 1909

THE CULTURE TEST

You are "taking chances" when you expect weekly culturing to assure your autoclaves' efficiency. It is common knowledge that 21 days incubation may be needed for cultures to show "growth" or "no growth."*

Culturing for sterility is the hospital equivalent of reading a 21 day old newspaper!

Conservative hospitals have been using Diack Controls for 46 years. They will continue to use Diacks to keep their enviable record of "no infections traced to autoclaves."

Research Laboratory of

Smith & Underwood

Chemists

Sole manufacturers of Diack Controls and Inform Controls

Royal Oak, Michigan

See page 116 Yearbook from Hospital Topics, Volume II

hydrated and with any salt depletion corrected; fluid losses during surgery should be carefully replaced. Frequent measurements of the patient's body temperature should be made (the posterior nasal temperature is convenient to measure and is satisfactory) in order to permit prompt recognition of heat retention in its incipiency and institution of appropriate therapy. In addition, cessation of sweating should be regarded as an urgent danger signal. The value of the water-cooled mattress in prophylaxis has already been mentioned. All of the preceding remarks apply with special force in children, in whom the factors of a small body mass, high internal heat production, and immature thermoregulatory responses make heat retention a particular hazard.

SUMMARY AND CONCLUSIONS

Temperature measurements were made in 212 patients undergoing surgery and general anesthesia. The body temperature of 164 adult patients undergoing lengthy operations was studied in relationship to environmental temperature and humidity and choice of anesthesia system. The temperature rebreathing anesthetic systems were made. The dry-bulb temperature under the surgical drapes was measured over a 20 F room temperature range.

The wet-bulb temperature is the most satisfactory measure of the thermal tolerability of an environment. Below 75 F wet-bulb temperature, heat retention is uncommon in adult subjects who are afebrile before operation. Above this temperature, body temperature rises progressively, and sometimes markedly, regardless of the anesthesia system used.

Below 75 F wet-bulb temperature, the height and rate of body temperature rise is slightly but consistently greater in patients anesthetized with the to-and-fro system than when the circle or non-rebreathing systems are used. Above this temperature heat retention is much more frequent when the to-and-fro system is used than when circle or non-rebreathing techniques are employed. The reasons for these effects are discussed.

Heat retention is usually associated with cessation of sweating under conditions where evaporation is the principal means of heat dissipation. The rate of body temperature rise during heat retention may be as high as 1.2 degrees F to 2 degrees F per hour in adults. Methods of prevention and treatment of heat retention during surgery and anesthesia are discussed.

SPECIAL ANNOUNCEMENT

The 1956 A.O.R.N. convention will be held January 24 to 27 at the Statler Hotel, Boston, Mass.

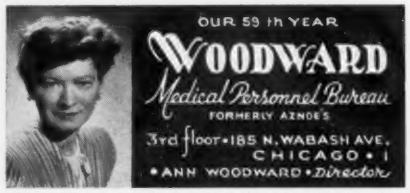
Please be sure your group has mailed an up-to-date list of officers to me at the National Headquarters office, 305 West 18th Street, New York City.

Edith Dee Hall
National Conference
Planning Chairman

(A paper from this year's A.O.R.N. Convention entitled "Spiritual Preparation of the Surgical Patient", by Rabbi Ferdinand M. Isserman, appears on page 24 of this issue.)

Note to Supervisors

We have a few back issues of the O.R. Yearbook from HOSPITAL TOPICS on hand.
If you find that your library is missing the 2nd, 3rd, or 4th volumes, let us know. We will furnish copies as long as our supply lasts.



Founders of the counseling service to the medical profession, serving medicine with distinction over half a century.

POSITIONS OPEN

O.R. SUPERVISORS: (a) Admin abil req'd; 8 rm suite; 300 bd vol gen hosp; Los Angeles area. (b) Lge univ hosp; desirable lge city; So. (c) Active surg serv; 5 rm suite; excel med staff; 150 bd gen hosp; twn 35,000; SE. (d) 400 bd teach'g hosp affil 2 imp med schs; 10 rm air cond suite; univ med ctr; E. (e) New 70 bd hosp opening soon; attrac coll twn; Tenn. (f) Vol gen hosp 60 bds; attrac twn; Pac NW. (g) Lge teach'g hosp; predom surg; super 20 RNs; to $4800; resort & univ city; MW. (h) Vol gen hosp 130 bds; twn 30,000; SW. (i) Active surg serv; some teach'g req'd; 250 bd gen hosp; lovely city; N. England. (j) Also serve as instr; coll affil sch; 400 bd gen hosp; lge univ city; MW. (k) Pref exp'd as asst; some teach'g req'd; fully apprv'd 150 bd gen hosp; attrac twn 30,000; E.

Award Competition Opens For Medical Students

The tenth annual Schering Award competition for medical students has been announced by Robert W. Burlew, M.D., chairman of the award committee. The purpose of the competition is to encourage medical writing and exploration of current research literature.

Titles of three subjects on which American and Canadian students may submit papers are: Current Concepts in the Management of Osteoporosis; Prevention and Treatment of Blood Transfusion Reactions; and Recent Trends in the Clinical Use of Adrenocortical Steroids.

Both a $500 first prize and a second one of $250 will be awarded for each of the three subjects. All students submitting papers of merit will be given professional gifts.

Deadline for entry forms specifying the choice of title is July 1. Manuscripts are to be mailed by October 1.

Further information on the competition is available from the Schering Award Committee, 60 Orange St., Bloomfield, N. J.

Practical Nurses, Maine U. Sponsor Summer Courses

The National Association for Practical Nurse Education and the University of Maine will co-sponsor courses for professional and practical nurses at the 1955 summer session of the university in Orono, July 5 to 22.

For professional nurses there will be courses for directors of schools of practical nursing and for instructors in these schools.

For practical nurses there will be two courses—an advanced one for those who have attended previous summer sessions and a course for those attending for the first time.

Further information may be obtained from Hilda M. Torrop, executive director, National Association for Practical Nurse Education, 654 Madison Ave., New York 21, N. Y.

Letourneau Accepts New Post

Charles U. Letourneau, M.D., has been appointed by the board of trustees of Northwestern University as director of the Program in Hospital Administration and associate professor of hospital administration. He succeeds Malcolm T. MacEachern, M.D., who will continue his association with the program as professor of hospital administration and with the title of honorary director.

Dr. Letourneau was on the staff of the American Hospital Association as assistant director, secretary of the Council on Professional Practice, and editor of *Trustee*.

CLASSIFIED ADS

— OPERATING ROOM NURSES —

Immediate appointments. 511-bed newly enlarged and finely equipped hospital. Ten operating rooms now completed. Northeastern Ohio stable "All American City" of 120,000. In center of area of recreational, industrial and educational friendly activities. Living cost reasonable. Within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio, and Pittsburg, Pennsylvania. Friendly and considerate working associates and conditions. Progressively advanced personnel policies. Starting salary $240.00 per month with four merit increases. Paid vacation, sick leave, recognized, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio by letter or collect telephone 4-5673.

— REGISTERED STAFF NURSES —

Immediate appointments. 511-Bed newly enlarged and finely equipped general hospital. Duty assignments in medical, surgical, pediatrics, psychiatric, obstetrics, or contagion units. Northeastern Ohio stable "All American City" of 120,000. In center of area of recreational, industrial, and educational friendly activities. Living costs reasonable. Within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio, and Pittsburgh, Pennsylvania. Friendly, cooperative work relations and conditions. Progressively advanced personnel policies. Starting salary $240.00 per month with four merit increases. Paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio by letter or collect telephone 4-5673.

specify HYLAND
SEROLOGY
REAGENTS
and get these extras at no extra cost
HYLAND STERILE SHEEP CELLS
10 CC., 30 CC., 100 CC., 300 CC.
extra weeks of use
Preserved in a Modified Alsever's Solution, Hyland Sterile Sheep Cells are usable for at least 10 weeks. Each lot thoroughly tested for reactivity, fragility, and sterility before release.
extra economy
When you buy Hyland Sterile Sheep Cells on standing order, you save all postage and shipping charges.
HYLAND GUINEA PIG COMPLEMENT
DRIED, WITH DILUENT, 3 CC., 7 CC., 20 CC.
extra ease of preparation
No ampule to break. Simply remove protective seals, inject diluent through Complement vial stopper, and shake vial. The resulting solution is light, clear and of uniform high titer.
HYLAND POSITIVE (4+) SEROLOGY CONTROL
LIQUID, 5 CC.
extra stability
Week in and week out, Hyland Positive (4+) Serology Control will verify proper reactivity of antigen and other reagents by exhibiting a typical 4+ reaction in all standard serologic tests for syphilis.
HYLAND VDRL ANTIGEN
5 CC., WITH 60 CC. BUFFERED SALINE DILUENT
extra convenience
Antigen and diluent are packaged in easy-to-use, amber screw-cap vials. No ampules to saw or snap. Serologically standardized to give clear-cut, completely reproducible reactions.
Hyland
HYLAND LABORATORIES
4501 Colorado Blvd., Los Angeles 39, Calif.
248 S. Broadway, Yonkers, 5, N. Y.

New Chief for Rheumatic Fever Study

Gene H. Stollerman, M.D., New York City, has been appointed to direct a research program on rheumatic fever at Northwestern University Medical School, Chicago. The study will be financed by the Samuel Sackett Foundation.

Dr. Stollerman is affiliated with New York University College of Medicine and is medical director of Irvington House, Irvington-on-Hudson, N. Y., which specializes in the study and treatment of children with rheumatic heart disease.

He will begin his new duties at Northwestern University July 1.

Two Schools Merge at Columbia University

On July 1 The School of Public Health and the Institute of Administrative Medicine at Columbia University will merge and become the School of Public Health and Administrative Medicine. The change was recommended because the scope of public health administration now includes the administration of medical care plans, prepayment hospital and medical insurance and hospital administration.

always a better product
now...a better package

HAEMO-SOL
now has the new, low, compact look
in its **all new, all metal** container

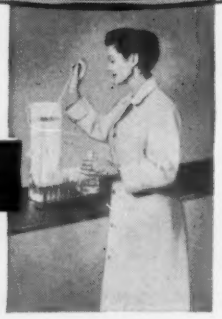
- Moisture proof product protection
- Wider opening—easier to dispense
- Every last ounce is at your finger tips
- No paper labels to get wet or soiled
- Triple tight cap for positive reclosing
- Squat shape will not tip over and spill
- Easier to store—easier to use

And, of course, inside is HAEMO-SOL the *original* cleaner and blood solvent, standard in so many hospitals and laboratories. Dissolves blood, disengages tissue, mucous, fat and proteinaceous soil on immersion alone.

Completely soluble—Crystal Clear Solution —Rinses Completely. Equally safe and effective for Metal, Glass, Rubber and Plastics. HAEMO-SOL cleans instruments, rubber gloves, syringes, lab glassware.

Yes! HAEMO-SOL is used for spinal syringes, blood bank, Bio-Assay and Tissue Culture work.

For Tracheotomy tubes, too, just soak and rinse.



It's so easy with Haemo-Sol!

"So practical—we can use the empties in many ways, too!"

FREE on request—detailed instructions—THE HAEMO-SOL WAY for cleaning catheters, syringes, instruments, needles, syringes for spinal anaesthesia, glassware, pipettes, wherever there is cleaning to be done by hand or mechanically.

Price per 5 lb. can • 12 cans-$5.40 each • 6 cans-$6.08 each • 1-5 cans-$6.75 each

MEINECKE & COMPANY, INC.
Serving the Hospitals of America for more than Sixty Years

225 Varick Street
New York 14, N. Y.

736 E. Washington Blvd.
Los Angeles 21, Calif.

2815 Main Street
Dallas 1, Texas

2560 Blake Street
Denver 17, Colo.

Ray E. Trussell, M.D., has been named executive officer of the combined school, DeLamar professor of administrative medicine and associate dean for public health. Dr. Trussell formerly was clinical professor of preventive medicine, New York University-Bellevue Medical Center.

Indiana Selected for Dietitian Study

Indiana has been selected for a pilot project to study the assistance to the dietary departments in small hospitals. The study is being sponsored by the Joint Committee of the American Hospital Association and the American Dietetic Association. Active participants will be Indiana's hospital association, medical association, Board of Health, and the dietetic association.

Many small hospitals with a capacity of less than 100 beds, find it difficult to meet high standards of nutrition and provide diet therapy because of the lack of a qualified dietitian. With the new project, it is hoped that dietitians can be found who will divide their services among two or more small hospitals.

When the techniques of the project have been perfected in Indiana, they will be put into practice on a nationwide basis.

Catholic Hospital Convention To be May 16-19

New trends in medicine, new community attitudes toward social problems related to medicine and the hospital's responsibility in meeting the changing concepts of health and disease will play a prominent role at the Catholic Hospital Association meeting to be held May 16-19, Kiel Auditorium, St. Louis, Mo.

New York University Receives $100,000 Grant

A grant of $100,000 to New York University by the Fannie E. Rippel Foundation of Newark, N.J., for support of research in the Institute of Cardiovascular Diseases and the Cancer Institute of the New York University-Bellevue Medical Center was announced recently by chancellor Henry T. Heald.

Dr. Edward A. Doisy Honored at Party

St. Louis University recently honored Dr. Edward A. Doisy, Nobel prize winning biochemist, by naming their Department of Biochemistry for him. The department will hereafter be known as the Edward A. Doisy Department of Biochemistry.

Dr. Doisy shared the Nobel prize in 1944 for isolating and determining the constitution and synthesis of vitamin K.

Central Supply

CABINET | DRY GOODS | SINK | GLASS | BLOOD | WRAPS | SOLUTIONS | RECEIVING

a section of special interest to

Central Supply Room Staff

contributions are welcome

Flask Technic for Sterile Surgical Fluids —A Guide to Planning

by

Margaret K. Schafer, Sr. N.O.

Nurse Consultant

Division of Hospital Facilities

Public Health Service

Department of Health, Education, and Welfare

● The use of hermetically packaged sterile distilled water or isotonic sodium chloride solution USP in hospital operating rooms, delivery rooms and nursing units instead of sterile water from water sterilizers is a recommended technic. To effectively introduce this technic requires the following steps:

I. Prepare an estimate of the quantities of solutions to be used.

The approximate daily requirement of flasks of isotonic sodium chloride solution and/or sterile water in hospital *operating rooms* and *delivery rooms* for hot packs, irrigations, and hand basins is 3-5 liters per operation and 4-7 liters per delivery.

The following charts based on 4 liters per operation and 7 liters per delivery shows the approximate daily number of flasks of sterile water and/or isotonic sodium chloride solution for hospital *operating* and *delivery* rooms:

Number of flasks of sterile water and/or isotonic sodium chloride solution for the *operating* and *delivery* room suite at 4 liters per operation and 7 liters per delivery:

Hospital Size	25	50	100	200
No. operations	2	5	10	20
No. births	1	2	3	6
Total—liters of solution	15	34	61	122
No. flasks				
2 liter flasks	6	13	24	48
1 liter flasks	3	8	13	26

Number of flasks of sterile water and/or isotonic sodium chloride solution for the operating room suite at 4 liters per operation:

Hospital Size	25	50	100	200
No. operations	2	5	10	10
Total liters	8	20	40	80
No. flasks				
2 liter flasks	3	7	15	30
1 liter flasks	2	6	10	20

Number of flasks of sterile water and/or isotonic sodium chloride solution for the delivery room suite at 7 liters per delivery:

(Continued on the next page)

[1] The term sterile surgical fluids is used to denote sterile water and/or isotonic sodium chloride solution USP for hot packs, wound irrigations or moist surgical dressings.

Hospital Size	25	50	100	200
No. births	1	2	3	6
Total liters	7	14	21	42
No. flasks				
2 liter flasks	3	6	9	18
1 liter flasks	1	2	3	6

In addition to the operating room and delivery room requirements, there is a small additional requirement for use on the nursing units, out-patient and emergency services.

II. Provide an area to prepare the solutions.
Surgical fluids are usually prepared in either the pharmacy or central supply department. If the hospital manufactures parenteral solutions, the surgical fluids should be prepared in the same area and should utilize the same equipment. If the hospital does not manufacture parenteral solutions, special provision must be made for surgical fluid preparations in either the pharmacy or central supply—preferably the pharmacy.

III. Provide equipment to prepare, sterilize, store and warm the solutions.

A. Preparation and sterilization equipment.

1. Water still with heat resistant glass storage carboy
2. Recording conductivity meter
3. Hot plate
4. Double compartment sink
5. Counter
   a. Unclean equipment
   b. Clean equipment and flasking
6. Cart—transporting and sterilizer loading
7. Bottle washer[2]
8. Flasks, glass, heat resistant, 1L—2L, and hermetically sealing caps
9. Scale—metric solution
10. Steam pressure sterilizer (autoclave) with corrosive resistant lining
11. Storage cupboards for equipment and supplies
12. Cart—flask drainage[2]
13. Closed system solution equipment—filtration and filling[2]

B. Provide storage space for the solution flasks.
Cabinets or cupboards are required in a central area, i.e., central supply or pharmacy, and in every hospital unit where solutions are used.

1. Central supply or pharmacy
Sufficient storage space for a reserve stock of solutions must be provided in the central supply or pharmacy storage area. The storage space should accommodate at least a 24 hour supply of solutions. However, it is considered practical to prepare solutions not oftener than once or twice a week. Thus, a 100 bed hospital preparing solutions twice a week would require central storage space for approximately 90 liters.

2. In the operating and delivery suite.
Storage cabinets must be provided in each operating room and delivery room or the adjacent sub-sterilizing room for a 24 hour quantity of type solutions required. Example, a 100 bed hospital with 4 operating rooms using a daily average of 40 liters of solutions daily would require cabinet space for 10 liters of solution in each operating room or cabinets for liters of solutions in the sub-sterilizing room between each two operating rooms.

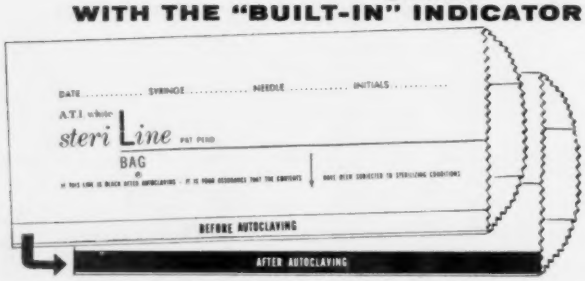
3. On the nursing units, outpatient, and emergency departments.
Some solution storage space must be provided in the clean utility room and treatment rooms.

C. Warmers
Solution warmers are required in each operating and delivery room or adjacent sub-sterilizing rooms.

IV. Assign personnel to the solution area.
Personnel provision must be made in the department preparing the surgical fluids. It has been estimated that it takes approximately 4 labor hours to prepare, sterilize, store and deliver 60 liters of solutions.

[2] Recommended in hospitals of 200 beds and over.

A.T.I. *Announcing the NEW*
steriLine BAG
® PAT. PEND.
WITH THE "BUILT-IN" INDICATOR



The ONLY sterilizing bag with a "steriLine Indicator"
...which changes color from white to black after autoclaving.

No longer do you have to guess whether your syringes, instruments, or needles have been autoclaved. Now, the new "steriLine Indicator" has been added! This "built-in" indicator changes color from white to black only after proper sterilizing conditions of time, steam and temperature have been met in your autoclave.

SteriLine Bags are available in usual sizes.

Test A.T.I. steriLine Bags FREE. Write today for FREE Sample steriLine Bags, literature and prices. GET ALL THE FACTS!

The steriLine Bags are a new development of the

Aseptic-Thermo Indicator Company

makers of STEAM-CLOX, COOK-CHEX and other sterilizing indicators.

11471 Vanowen Street
North Hollywood, California

STERILINE BAGS HT 5
Aseptic-Thermo Indicator Company
11471 Vanowen St., No. Hollywood, Calif.
☐ Please send free samples and information.
☐ Please have service representative call.
My name_____
Title_____
Hospital_____
Address_____
City_____ Zone___ State____

Furred Tongue Not a Symptom Says British Doctor

The furred tongue is no reflection of a person's general health, says B. Gans, M.D., Miller Hospital, London. Nor is it an indication of the condition of a person's tonsils, respiratory tract or teeth, the doctor believes.

Reporting in a recent *British Medical Journal*, Dr. Gans said that in a study of 750 children he found no scientific basis for the belief that a furred or coated tongue was a symptom of disease.

Summer Workshop on "Effective Organization"

The Frances Payne Bolton School of Nursing, Western Reserve University, Cleveland, Ohio recently announced a non-credit workshop to be held June 27-July 1 entitled *Effective Organization: A Prequisite to Good Human Relations.*

The workshop is open to administrative supervisors, assistant directors and directors of nursing service.

Discussion will be focused on the responsibilities of the nursing service administrator for sound organization structure and effective delegation of work.

Salk Named Winner of $10,000 Prize

Jonas Salk, M.D., creator of the Salk polio vaccine will be the 1955 recipient of the $10,000 tax free Mutual of Omaha Criss award and gold medal, according to an announcement by Charles W. Mayo, M.D., of the Mayo clinic.

Best Hospital Pharmacy Display Will Receive Award

The American Pharmaceutical Association will offer an award for the best pharmacy display in a hospital arranged by hospital pharmacists during National Hospital Week.

Two 8 by 10" glossy photos of entries are to be sent to American Society of Hospital Pharmacists' secretary Gloria Niemeyer, 2215 Constitution Avenue, Washington 7, D.C., not later than June 1 for judging.

Allsever Named Medical Director

South West Blood Banks, Inc., have appointed a full time medical director. He is John Allsever, M.D., formerly with the United States Public Health Service. Dr. Allsever takes over his new duties on July 1st.

Passano Foundation Award

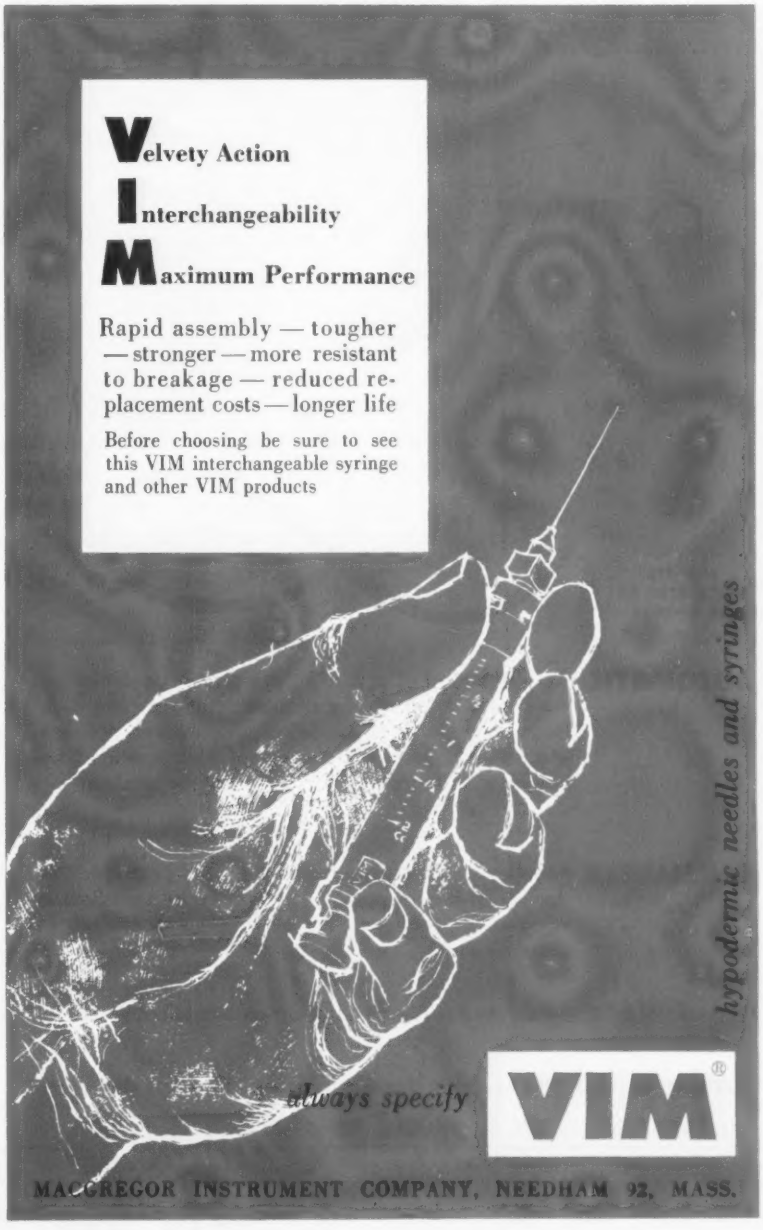
Vincent du Vigneaud, M.D., professor and chairman department of Biochemistry, Cornell University Medical College, New York City, has been selected as the recipient of the $5000 Passano Award for 1955.

The award is to be made to Dr. du Vigneaud on June 8 in recognition of his investigation of the chemical and physiologic nature of the hormones of the posterior portion of the pituitary gland. This investigation culminated in the identification and synthesis of oxytocin and vasopressin.

New Jersey Academy Extends Membership

The New Jersey Academy of Science is extending membership opportunity to licensed registered nurses and to all nurses holding a degree. They are now eligible to join either the "Education Section," "Psychology Section," "Medical Sciences" or "Social Sciences" section, depending on their individual qualifications.

Out-of-state persons are eligible for membership also, under specific conditions.


Velvety Action
Interchangeability
Maximum Performance
Rapid assembly — tougher — stronger — more resistant to breakage — reduced replacement costs — longer life
Before choosing be sure to see this VIM interchangeable syringe and other VIM products
hypodermic needles and syringes
always specify
VIM
MACGREGOR INSTRUMENT COMPANY, NEEDHAM 92, MASS.

Catholic Hospital Association To Sponsor Summer Courses

The department of Hospital Administration, St. Louis University, in cooperation with the staff of the Catholic Hospital Association, will offer a series of summer courses in hospital administration and hospital accounting for administrators this year.

A course in *Introduction to Hospital Accounting* will be held June 21-July 2. This is designed for those who have not had formal preparation in basic accounting. A *Hospital Accounting* course from July 5-July 23 will consist of a brief review of hospital accounting principles, and from July 5-23 a course in *Introduction to Hospital Association* will also be taught.

Medical Student Research Fellowships

Medical school students throughout the United States and Canada are eligible for fellowships being offered by Lederle Laboratories.

Purpose of the fellowships is to relieve some of the financial burden from students who desire to devote their summer vacations to basic research in the preclinical medical sciences.

ROBBINS *Automatic* TOURNIQUET

OPERATING ROOM MODEL

Two containers of Freon (one always in reserve)
Inflatable cuff easily applied and removed
Any desired length of tubing
ON

NO. 975
PRICE $100.00
AS SHOWN

U. S. patent applied for by ROBBINS INSTRUMENT CORPORATION

AUTOMATIC Quick inflation of cuff. The pressure is governed by the control knob to any desired setting on the dial. May be pre-set to any reading. The desired pressure is absolutely maintained constant until changed by turning the control knob or released by pushing the ON-OFF switch.

RELIABLE Absolutely reliable in maintaining set pressure. No danger of loss of pressure even if Freon container is removed or changed. No need to constantly watch accurate dial.

SAFE Freon used is non-toxic and non-inflammable.

Write, wire or phone for a demonstration—Prompt delivery

ZIMMER MANUFACTURING CO. WARSAW, IND.

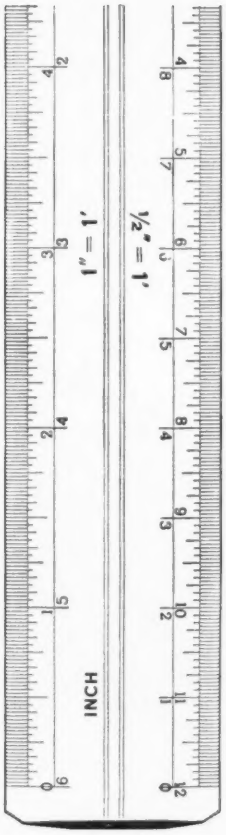
Zimmer

In Canada Available through selected surgical supply dealers or through our Agents, Fisher & Burpe, Ltd.

Look for the trademark

ADVERTISERS' INDEX

American Hospital Supply Corp. ...2nd Cover
American Sterilizer Co. 55
Ames Co., Inc. 28
Gordon Armstrong Co. 40
Aseptic-Thermo-Indicator Co. 86
C. R. Bard, Inc. 34
Bard Parker Co. .....3rd Cover
S. Blickman, Inc. 59
Robert Busse & Co., Inc. 45
Wilmot Castle Co. 67
Chesebrough Mfg. Co. 61
Gilbert Hyde Chick Co. 11
Ciba Pharmaceutical Products, Inc. .....52 and opposite page 20
Classified Ads 57, 58, 82, 83
Cutter Laboratories 72
J. A. Deknatel & Son, Inc. 65
Ethicon, Inc. .....opposite page 60
Everest & Jennings, Inc. 10
Flex-Straw Corp. 71
Gendron Wheel Co. 49
Gudebrod Bros. Silk Co., Inc. .....between pages 44 and 45
Harold Supply Corp. 54
Hausted Mfg. Co. 1
Health Insurance Council 33
Hoffmann La Roche, Inc. 60
Hyland Laboratories, Inc. 83
Johnson and Johnson .....opposite page 8
Lakeside Laboratories, Inc. .....4th cover
Walter G. Legge Co. 71
Eli Lilly & Co. 6
Macalaster Bicknell Parenteral Corp. 63
MacGregor Instrument Co. 87
Medical Instrument Repair Co. 39
Meinecke & Co. 84
Miles Laboratories 43
Ohio Chemical & Surgical Equipment Co. ..69
Orthopedic Equipment Co. 68
Parke, Davis and Co. 18
Pelton and Crane Co. 66
Pfizer Laboratories, Div. Chas. Pfizer & Co. .70
Physicians' Record Co. 4
Presco Co., Inc. 8
E. M. Rauh & Co., Inc. 62
Chas. A. Schmidt Surgical Instrument Co. ..64
Seamless Rubber Co. .2 and opposite page 45
Smith and Underwood 82
Edward Weck & Son, Inc. 5
Winthrop Stearns, Inc. 36
Zimmer Mfg. Co. 88



by any measure it's

BARD-PARKER RIB-BACK SURGICAL BLADES

and by any measure it is just as true today as when our Company was founded . . . in the purchase of B-P RIB-BACK SURGICAL BLADES you are provided with the most dependable cutting edges that modern scientific methods and *the art of accuracy* can produce . . . their performance in use is the answer to the question of economy!

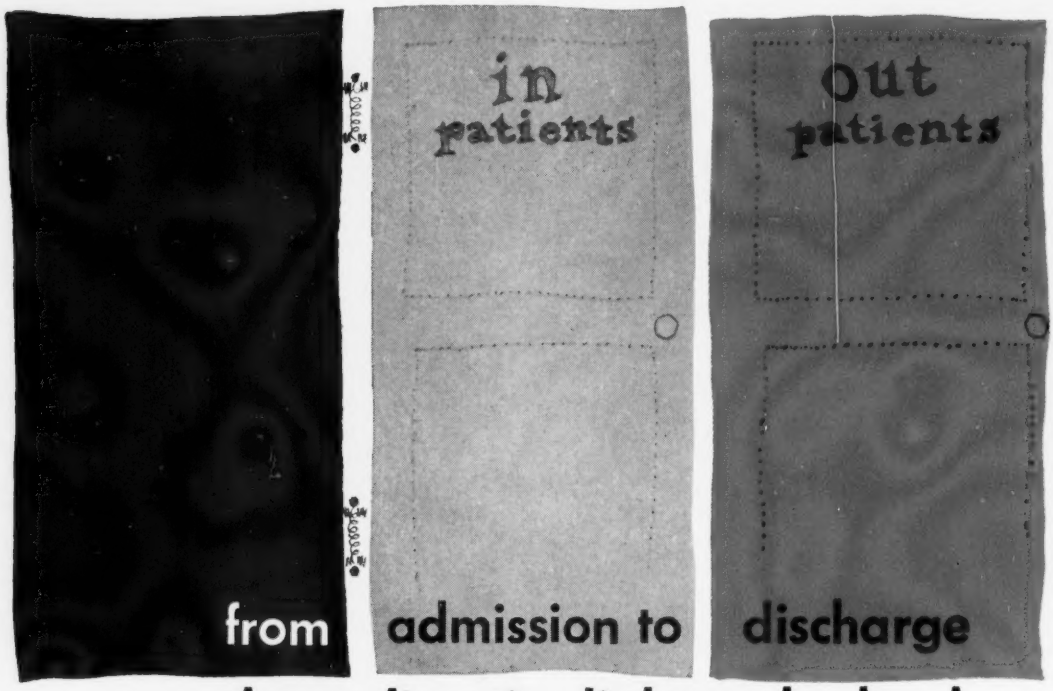
Ask your dealer

BARD-PARKER COMPANY, INC.
Danbury Connecticut, U.S.A.

ENDURING CUTTING EDGES • UNIFORMLY SHARP • QUALITY AND DEPENDABILITY •

It's Sharp

RIB-BACKS packaged in the *new* RACK-PACK eliminates unwrapping, handling or racking of individual blades. A real *time* and *labor* saver for the O.R. personnel. *In a matter of seconds* from RACK-PACK to sterilizer.



these diuretics lighten the load

Prompt response to a diuretic with a minimum of side effects shortens the hospital stay and simplifies patient-care, easing the load on hospital and patient.

Time-tested and dependable, MERCUHYDRIN and NEOHYDRIN effectively decrease cardiac work-load by relieving edema. Because dosage need not be interrupted, they produce sustained diuresis and improvement which aids earlier discharge of cardiac patients.

standard for initial control of failure

MERCUHYDRIN®

sodium

BRAND OF MERALLURIDE INJECTION

for maintenance

NEOHYDRIN®

BRAND OF CHLORMERODRIN

replaces injections in 80 to 90% of patients

Leadership in diuretic research

Lakeside LABORATORIES, INC.

MILWAUKEE 1, WISCONSIN

Return Postage Guaranteed
HOSPITAL TOPICS
30 West Washington St.
Chicago 2, Illinois

Entered as second class matter at the Post Office at Chicago, Illinois